

PD-ABN-840

**EVALUATION OF THE HEALTH CARE
FINANCING AND SERVICE DELIVERY
REFORM PROGRAM IMPLEMENTED
BY ABT ASSOCIATES, INC.
(CCN-0004-C-00-4023-00)**

April 21, 1997

Submitted to USAID/W ENI/DGSR/HRHA
under
USAID/ENI/DGSR Technical Assistance Project
(Contract No. DHR-0037-C-00-5067-00;
Task Order 96-0008)

By
George A. Laudato, Team Leader
Larry Barenbaum
Christopher Bladen
Harris A. Berman, MD
John M. Merenna
Clydette L. Powell, MD
Anthony F. Vuturo, MD
Robert S. Wilkinson
David L. Woodrum

USAID/ENI/DGSR Technical Assistance Project
BHM International, Inc.
1800 North Kent Street, Suite 1060
Arlington, VA 22209

**This report may be ordered from:
USAID Development Experience Clearinghouse
1611 North Kent Street
Suite 200
Arlington, VA 22209
Phone: (703) 351-4006
Fax: (703) 351-4039
e-mail: cdie_document_order@disc.mhs.compuserve.com**

TABLE OF CONTENTS

	<u>PAGE</u>
ACKNOWLEDGMENT	iv
ACRONYM LIST	vi
EXECUTIVE SUMMARY	viii
I. INTRODUCTION AND BACKGROUND	1
II. THE ZDRAVREFORM PROGRAM	7
A. CENTRAL ASIA	7
B. UKRAINE	11
C. RUSSIA	13
D. CROSS-REGIONAL OBSERVATIONS AND RECOMMENDATIONS	15
E. CROSS-REGIONAL INFORMATION SHARING AND LESSONS LEARNED	19
III. RECOMMENDATIONS	21
A. PROJECT DESIGN	21
B. PROJECT MANAGEMENT	21
C. CLINICAL ISSUES	22
D. PAYMENT METHODS	22
E. INFORMATION MANAGEMENT	23
ANNEXES	
ANNEX A: SCOPE OF WORK	
ANNEX B: CENTRAL ASIA	
ANNEX C: UKRAINE	
ANNEX D: RUSSIA	
ANNEX E: LIST OF PERSONS CONTACTED—CENTRAL ASIA	
ANNEX F: LIST OF PERSONS CONTACTED—UKRAINE	
ANNEX G: LIST OF PERSONS CONTACTED—RUSSIA	
ANNEX H: EVALUATION TEAM MEMBERS	
ANNEX I: EVALUATION OF THE HEALTH CARE FINANCING AND SERVICE DELIVERY REFORM PROGRAM IMPLEMENTED BY ABT ASSOCIATES, INC. (IN RUSSIA AND UKRAINE)—PHASE I REPORT	
ANNEX J: DIRECTIONS FOR HEALTH REFORM STRATEGY DEVELOPMENT IN UKRAINE (paper by Marty Mäkinen, PhD)	

The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of the USAID/ENI/DGSR Technical Assistance Project, BHM International, Inc., or the staffs of these organizations.

ACKNOWLEDGMENT

Many people contributed valuable insight and analysis to this report. The evaluation team would like to thank all of them. There was, however, one person who deserves special recognition. Wendy Lee Wallace, the Health Sector Advisor for USAID's Bureau for Europe and the New Independent States, Human Resources, Health and Population Division, contributed invaluable time, energy, insight, and understanding. Her technical knowledge of health care reform issues, her understanding of the politics, economics, culture, people, and language of the region added depth and validity to much of the work done by the team. Her tireless pursuit of information throughout the two months that the team looked at ZdravReform, and her willingness to share her analytic understanding with other team members and the professionals with whom the team dealt, were critical to the successful completion of this report. The entire evaluation team takes this opportunity to thank her.

[THIS PAGE INTENTIONALLY LEFT BLANK]

ACRONYM LIST

AIHA	American International Health Alliance
AMI	acute myocardial infarction
APTK	obstetrician-gynecologist, pediatrician, and internist collective
ARI	acute respiratory infection
BASICS	Basic Assistance for Institutional Children's Survival
CAR	Central Asian Republics
CD-ROM	compact disk read-only memory
CDD	control of diarrheal disease
CME	continuing medical education
COTR	contracting officer's technical representative
CPR	cardiopulmonary resuscitation
CPT	common procedures of technology
CT	computerized axial tomography (same as CAT scan)
CVA	cerebro-vascular accident
CVD	cardiovascular disease
DHS	Demographic Health Survey
DRG	diagnostic-related groups
DSM	drug system management
EKG	electrocardiogram
ENI	Europe and the New Independent States
FAP	feldsher midwife health point
FGP	family group practice
FIS	financial information systems
FMA	family medicine ambulatory
FMD	family medicine department
FY	fiscal year
GDP	gross domestic product
GFA	geographic focus area
GKM	State Property Management Committee
GKP	State Privatization Committee
HCFSDR	Health Care Financing and Service Delivery Reform
HEDIS	Health Plan Employer Data Information Set
HFS	Health Financing and Sustainability
HMO	health maintenance organization
HPA	Health Protection Act
ICD-9	international classification of diseases-9
ICU	intensive care unit
IDS	intensive demonstration site
IS	information systems
IUD	intrauterine device

KGB	Committee for State Security
km	kilometer
L&A	licensing and accreditation
MEDECA	Medical Economics Automation System in Dnepropetrovsk
MES	medical economic standards
MHI	mandatory health insurance
MI	myocardial infarction
MIS	management information system(s)
MOF	Ministry of Finance
MOH	Ministry of Health
NCHS	National Center for Health Statistics
NEM	New Economic Mechanism
NGO	nongovernmental organization
NIS	New Independent States
OCH	oblast clinical hospital
OECD	Organization for Economic Cooperation and Development
OHCC	oblast health care committee
OHD	oblast health department
P&T	pharmacy and therapeutics
PFM	polyclinic of family medicine
PM	program manager
QA	quality assurance
QI	quality improvement
RFP	request for proposals
RPM	rational pharmaceutical management
SES	Sanitary and Epidemiological Service
SMU	Siberian Medical University
SOAP	subjective, objective, assessment, and plan
SOMARC	social marketing
SPHA	School of Public Health Administration
STD	sexually transmitted disease
STLI	Scientific Technology and Language Institute
SUB	rural district hospital
SVA-FAP	rural physician ambulatory/feldsher midwife health point
TB	tuberculosis
THIF	territorial mandatory health insurance fund
UCO	University of Colorado
UNDP	UN Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDHHS	United States Department of Health and Human Services
VAT	value added tax
WHO	World Health Organization

EXECUTIVE SUMMARY

The ZdravReform program is an important element of U.S. economic assistance to the New Independent States of the former Soviet Union. The program grew out of the discussions held between President Clinton and President Yeltsin in Vancouver in spring 1993.

Both then and now, reform of the health care system remains an important determinant of the success of the overall economic and democratic transition of the former states of the Soviet Union. Before the dissolution of the Soviet Union, the population's health status was poor relative to the West. The financial crisis that developed after dissolution has spelled further deterioration of the health care system. The original vision of the ZdravReform program was to assist the new republics in applying the latest technology to health care financing as a means of bolstering the social safety net while economic transition proceeded.

Serious experimentation in health care reform had been underway in the former Soviet Union since the late 1980s. Control over the health care system had been decentralized, new enabling legislation had been passed at the national and local levels, and mandatory health insurance laws had been enacted by localities. From the inception of its program in the early 1990s, USAID provided assistance on health care reform matters. The Vancouver Summit of April 1993 created an urgency about helping solve the problems of health care delivery in the transition economies.

It was into this environment that the ZdravReform program was introduced. While the program set out to test new models of health care financing, it quickly evolved to address service delivery as an important element of reform and to reevaluate the assumption that health care delivery would quickly shift from the public to the private sector.

As the evaluation of the program got underway, ZdravReform was testing models of health care finance and service delivery reform throughout the New Independent States (NIS). From Almaty in the east on the border of China to a rural rayon in Ukraine on the border with Moldova in the west; from Issyk-kul in the Kyrgyz Republic in the south to Central Russia and Siberia in the north, health care providers were testing new ways to deliver and pay for high-quality health care. It was a rapid start for a complex undertaking that needs time to mature and develop.

The evaluation looked at the technical impact of the project and the validity of the model systems subject to testing. It also looked at program management, project implementation, and project design issues. And, finally, it sought to understand the relationship between health care reform in the NIS and the broader objectives of the United States such as economic restructuring and democratic transition.

The evaluation team conducted interviews and site visits in Washington, D.C., Kazakstan, the Kyrgyz Republic, Ukraine, and Russia. Its principal findings were that

C health care reform is critical to the success of the overall economic transition underway in all of the countries surveyed. It has a vital supporting relationship to the ENI Bureau's

strategic objectives in the area of economic transition and democratic liberalization.

- C health care reform issues should remain part of the policy dialogue agenda of each of the U.S. Missions in the region.
- C the work on health care reform has been technically sound and successful and should be continued.
- C the project design was sufficiently flexible to allow project implementation to change and evolve as conditions warranted. The “rolling” design was one of the strongest contributors to project success.
- C the project concentrated on conducting tests and setting up model systems at the local level or oblast level rather than at the national level. This productive approach remained highly responsive to the on-the-ground environment.
- C an immense amount of work has been undertaken in the three regions. In Russia alone, more than 100 subprojects were developed. Communications between the various test sites and the health care providers working at them needs to be encouraged to ensure dissemination of lessons learned.
- C in the case of Russia, the decision to move the project management function out of Washington to the field was the proper one. For the Central Asia and Ukraine programs, discussions between USAID and the field about streamlining communication are underway and should be continued to preserve project momentum.
- C while clinical training was not part of the original project design, it emerged as an important determinant of project and reform success.
- C Western concepts of quality improvement have not found a receptive environment in the region. The former Soviet Union’s traditional management approach places much greater emphasis on control. Further assistance is needed and must focus on patient outcomes.
- C any follow-on work should continue to test the primary payment models that have been the core of the current effort.
- C declining health budgets and a limited tax base for assessing health taxes to finance national health insurance systems have reinforced the use of under-the-table payments in all the countries visited. A way needs to be found to legalize these payments.
- C the work on information management is important to the success of the overall reform effort. It is a new aspect of the health system and needs continued technical support.

I. INTRODUCTION AND BACKGROUND

Since the breakup of the Soviet Union in 1991, each of the resulting countries has assumed primary responsibility for managing its own economic and political transition. While each transition has been different, certain key problems are similar and need to be solved if the overall process is to succeed. Against this backdrop, President Clinton and President Yeltsin met in Vancouver in spring 1993. At the meeting, they agreed that the United States would support the new countries of the former Soviet Union with a major assistance program targeted at helping them successfully make the transition to democratic political structures and open market-oriented economic systems.

Part of the assistance pledged at the Vancouver conference focused on a major effort to reform health care financing and service delivery in the New Independent States (NIS). In its strategic planning for the NIS, USAID has taken into account the reality that one of the primary determinants of a successful economic and democratic transition is how well the NIS can maintain an adequate social safety net while navigating the tricky waters of transition. The idea received the support of numerous academicians and scholars who have studied the region. In addition, all agreed that the health care system is one of the most important social systems and thus needs to operate efficiently and effectively.

To support reform in the health care sector, USAID designed the ZdravReform program for the NIS. After a full and open competitive procurement process, USAID awarded a contract to Abt Associates, Inc., a recognized management consulting firm with an international reputation in the health field, to manage the ZdravReform program.

The Health Environment. Even before the dissolution of the Soviet Union, the health status of its people was poor relative to the West. Life expectancy had remained constant since 1970. Poor adult health and high rates of infant and maternal mortality and noncommunicable diseases did nothing to extend average life expectancy. Added to this situation are the financial crises that developed in the NIS after dissolution. Not surprisingly, the health care system faced a near crisis. Health commodity supply lines dried up; doctors and other medical personnel were paid late or not at all; general nutritional standards declined and the excessive size of the overall medical system simply could not be maintained. These conditions have resulted in an even lower quality of care than that in the Soviet Union's predissolution days.

To meet this challenge and avoid a total breakdown in the health care system, each of the NIS governments has to a greater or lesser extent been forced to decentralize much of the responsibility and authority for health care systems and other social safety net functions to local and regional authorities. They have also had to look beyond state solutions to the marketplace to find help in meeting the demand for services. The World Bank succinctly described the situation as follows: "the pressing concern for policy makers is to prevent a further decline of health indicators while restructuring health financing and management to reduce costs and improve the quality of care."

Health Care Reform. It is important to note that reform in the health care sector was underway and vigorous before initiation of the ZdravReform program. Indeed, the first reforms were introduced

in 1987. Before 1987, however, the entire system was public and controlled from the center. With all facilities owned by the state and all medical care personnel employed by the state, the distinction between financing and provision was nonexistent. The Soviet Union Ministry of Health determined the budget and relied heavily on such quantitative production norms as number of facilities, manpower, and hospital bed days of care. The ministry allocated equipment to the republic health ministries and then to the regional and local levels.

In 1987, management of the health care system was decentralized to the republic level. The republics assumed primary responsibility for managing both the financing and delivery of care. Nevertheless, deviations from the USSR MOH spending plans and set medical standards (prekazy) were relatively minor. Upon the dissolution of the Soviet Union, however, power and control devolved to the republics concomitant with receipt of taxing authority. With the exception of Russia, where the central government has decentralized most budget and decision-making authority for the health sector to the local government at the oblast or state level, the system within the republics remains highly centralized at the national level. The difference between operating in a highly decentralized government structure such as Russia's and in still-centralized structures such as Central Asia's and Ukraine's has had an important impact on the ZdravReform project. This is particularly true for the national-level policy work, which has been less successful than the oblast-level work in Russia, Ukraine, and Kazakstan.

Most of the NIS governments began the health care financing and service delivery reform process by drafting the legislative initiatives of the "health sectors." They passed new laws that defined the principles, legal rights, and organizational structures needed to move the sector toward a market orientation. They also passed laws that shifted the system away from concepts of fixed chapter budgeting and, except for Ukraine, introduced more efficient systems of health care financing such as health insurance.

In the pilot sites, redefining medical practices at the operational level has meant decentralizing the service delivery infrastructure and allowing for far greater diversity and competition among providers. In almost all cases, the primary element undergoing consideration and testing is the separation of payment from the provision of care. The pilot sites are jettisoning fixed chapter budgets in favor of more market-oriented mechanisms such as health insurance and incentive-based payments that reward service providers for efficiency, effectiveness, and quality of care.

Many of the countries have enacted health care insurance laws that create compulsory insurance programs for entire populations within a country; Russia has authorized voluntary insurance to provide supplementary benefits. These systems are still evolving; each republic is at a different stage in its thinking and the operationalization of the systems.

ZdravReform. It was in this environment, in which change was possible for the first time, that ZdravReform was introduced. The primary conclusion of this evaluation is that the project has been extremely successful in helping shape change and that the technical assistance provided under the project has had a noticeably high marginal return. While the program's success relates to numerous factors, one of the most important is the realization among counterparts and others in the NIS that

for an equitable health care system to survive, it must evolve and change to meet the needs of the people in an open, democratic market-oriented society.

The ZdravReform program set out in the pilot sites to help increase economic efficiencies, quality of care, access, and provider choice in the NIS through market-oriented reforms in the health care finance and service delivery systems. The project proposed to focus on the following activities:

- C rapid-response assistance over a wide range of health care financing and service delivery system issues and the introduction of related systems, including U.S.-based management information systems, cost-accounting and budget systems, quality assurance, health management and administration, and principles of consumer choice, access, and responsibility;
- C extensive customized training;
- C five to seven intensive demonstration sites to test health care reforms that could be replicated by the NIS governments countrywide;
- C an innovative small grants program to support NIS reformers; and
- C effective dissemination of reform efforts and lessons learned.

The project began in Russia and Kazakstan in mid-1994, and a U.S. headquarters was established. Work got underway in the Kyrgyz Republic and Ukraine later in 1994, shortly to be followed by limited work in Turkmenistan and Uzbekistan. By December 1994, ZdravReform offices were open in Moscow, Kyiv, and Almaty. The project established ongoing operations in all the sites listed below (the evaluation team was able to visit all sites except Tver and Shymkent).

- C Moscow, Russia (regional office)
- C Siberia GFA (geographic focus area), including Novosibirsk, Altai Krai, Tomsk, and Kemerovo
- C Central Russia Cities (Tver and Kaluga)
- C Kyiv, Ukraine (regional office)
- C Lviv, Ukraine (IDS) (intensive demonstration site)
- C Odessa, Ukraine (IDS)
- C Almaty, Kazakstan (regional office)
- C Dzhezkasgan, Kazakstan
- C Semipalatinsk, Kazakstan
- C Shymkent, Kazakstan (IDS)
- C Issyk-kul, Kyrgyz Republic (IDS)

Since 1994, the ZdravReform program has evolved to take into account two separate sets of changes: external changes in the NIS and USAID program management trends. Adjustments to the external

trends were necessary, but they have slowed project implementation and led to the creation of a set of moving targets for measuring program success. Another successful element of the project identified by the evaluation team was the rolling design, which allowed for regular adjustments to project implementation and helped in setting new targets when necessary. The rolling design has permitted the project to shift and adapt to the rapidly changing environment of the NIS.

Changes in the NIS Environment. USAID developed the ZdravReform project against a set of guiding assumptions about reform in the NIS. One central assumption held that the public sector functions, including health care delivery, would rapidly shift to the new private sector. It is now clear that such a transition will not occur at least over the short to medium term. The only privatization process assisted by the ZdravReform program has been the “Farmatsiya” privatization in Kazakstan, the government’s pharmacy distribution program (see Annex B.1).

While efforts to increase the private sector’s involvement in the delivery of health care services continue under the ZdravReform program, they are not the cornerstone of the program. Instead, the concepts driving the ZdravReform effort throughout the NIS can more accurately be described as

- Ⓒ decentralization of management authority, particularly budget authority;
- Ⓒ devolution of decision making;
- Ⓒ fostering human resource capacity;
- Ⓒ building health care management expertise; and
- Ⓒ introducing U.S.-based concepts of incentive payments and quality assurance.

Changes in USAID Program Trends. During the program’s startup year, USAID decided to modify the Russia portion of the program to address counterpart needs more directly, to encourage partnership-driven activities, and to delegate more decision-making authority and contractual responsibility to the Mission. Clearly, USAID succeeded in its efforts, and the evaluation team concluded that this approach was appropriate for Russia.

The shift in the Russia program illustrated the value of the rolling design to ensure efficient project implementation. The flexibility afforded by the rolling design has kept ZdravReform highly relevant to the changing environment of not only Russia, but also of Ukraine and Central Asia.

The Evaluation. The evaluation unfolded in two phases. Phase I in late May and early June 1996 captured the institutional memory of essential USAID and Abt Associates project staff before their departure from the program. A team of three evaluators analyzed project documents, met with USAID and Abt staff in Washington, and made field visits to Kyiv, Ukraine, and Moscow, Russia. They interviewed all the major project personnel and produced an evaluation that considered most of the key project design and implementation issues (see Annex I).

The full evaluation drew heavily on the Phase I work. Many of the observations contained in the Phase I report are reflected in the findings and recommendations of this report and in the supporting annexes. The full evaluation was conducted in September and October 1996. While Phase I looked most closely at management and design issues, the full evaluation focused most of its attention on impact issues, including the overall impact of the project and its contribution to the achievement of

the strategic objectives of the ENI Bureau and the technical impact of the project in terms of financial, management, pharmacy privatization, information, clinical, and quality assurance systems. The team also looked at the on-the-ground management structures in Central Asia, Ukraine, and Russia.

Ten people actively participated in the more than 150 interviews conducted in Washington, D.C.; Almaty, Kazakstan; Dzhezkazgan, Kazakstan; Semipalatinsk, Kazakstan; Issyk-kul, Kyrgyz Republic; Kyiv, Ukraine; Lviv, Ukraine; Odessa, Ukraine; Moscow, Russia; Kaluga/Tula, Russia; and Siberia (Novosibirsk, Altai Krai, Tomsk, and Kemerovo), Russia. The team brought to the interviews many years of experience in health care financing, health care organization, information systems management, clinical practice, and public policy analysis. The field interviews were conducted in medical facilities and in operating health care financing organizations throughout the region—often in rural settings.

The key findings and recommendations follow (page 21). Voluminous technical sectoral and geographic findings and recommendations are presented in the three geographic annexes (Annexes B, C, and D).

[THIS PAGE INTENTIONALLY LEFT BLANK]

II. THE ZDRAVREFORM PROGRAM

The New Independent States of the former Soviet Union can point to a strong supporting relationship between the substantive reform of their respective health care systems and the overall success of their respective transitions to democratic market-oriented societies. As the old social support systems of government service have given way either through conscious national policy or serious underfunding, the average citizen has experienced a noticeable erosion in the quality of life. People are seriously concerned about how they will be able to gain access to even the most basic services.

Unless the health care system is fixed or, at a minimum, the general public believes that serious work is underway to ensure citizen access to quality care, attitudes toward the new economic systems emerging from the transition process could turn negative. The threat of a reversal in attitudes even extends to the professionals who run the health care systems. They represent an important pool of opinion on local and national policy. They see and talk to thousands of people daily and thus have a direct role in shaping public support or criticism.

In addition to the role that health care reform plays in supporting the overall economic transition throughout the NIS, the ZdravReform program in Central Asia, Ukraine, and Russia has reinforced that support by using development tools that add to the movement toward democratic market-oriented societies. The program has operated in a highly decentralized fashion, helping break the old “single solution imposed from above” model of the former centrally planned system. It has supported several market-driven incentive-based payment experiments and introduced forms of voluntary organization outside the formal government, in many cases for the first time. It has introduced an element of choice as to health care providers and has generally been a building block in the nascent civil society movement, particularly in rural areas and the oblasts.

A. Central Asia

While looking at the technical issues associated with ZdravReform in Central Asia, the evaluation team had a unique opportunity to consider the design and management of the program as well. The team was not able to interview all major participants involved in the design and early implementation of the program, but it was able to tap sufficient institutional memory in Washington and the field to develop an image of the environment in which the project was designed and initiated. The team succeeded in weaving management and design questions into all interviews, meetings, and question-and-answer sessions that followed formal briefings.

The core findings are that

1. the Central Asia ZdravReform program is well managed by both the USAID Mission and the Abt field team. The Abt team has provided exceptionally effective technical assistance, and the Mission has kept the project focused and accelerated the program’s pace as it has taken on national-level expansion. Part of this expansion has been the leveraging of other major donor assistance;
2. the project is meeting or exceeding the targets outlined in the annual work plans;

3. the project is making a major contribution to the achievement of Central Asia's and ENI's strategic objectives;
4. the project's core design and implementation are efficient and effective in delivering high-quality technical assistance focused on health care reform;
5. the Issyk-kul oblast program design is a highly integrated pilot project that addresses within one oblast the fundamental health care reform elements: health insurance, provider payment, creation of a working primary care system through independent family group practices, quality assurance, management information systems, and consumer participation and choice; and
6. the pharmacy industry privatization program has been well managed by the contractor and has succeeded.

The team spent considerable time looking at the different roles played by the centralized project support offices—Abt/Bethesda and USAID/Washington—and the Central Asia support and implementation offices—Abt/Almaty and USAID/Almaty. The team drew conclusions concerning the locus of project management, the rolling design, respective roles in the next steps, and lessons learned and information exchanges.

The Locus. The original design that developed out of the proposal and contract process envisioned country site-specific health care reform interventions as a means of testing and developing new ways of financing health care in the NIS. Given that the interventions were spread out over several countries, the project called for a strong management role for both the contractor's central office—Abt/Bethesda—and for the USAID/Washington project management office—ENI/HR/HP. The approach was consistent with conditions on the ground in the original target countries at the time the project was put in place. In particular, the USAID Missions in the field were new and often understaffed, and USAID as an agency had only relatively recently gained experience in working with transition economies.

There was considerable political pressure from the State Department and internal pressure from USAID to start the process of health care reform throughout the NIS as soon as possible. The model for providing assistance in health care reform was flexible. The contractor would field teams to analyze on-the-ground conditions and then propose site-specific programs for testing various models of reform and financing. Successful interventions could then be replicated on a broad and sustainable basis. In effect, the design was not locked in at the inception of the project but rather would develop and evolve as the project matured. It took on the character of a rolling design.

Given the project's central management control and its highly flexible operational design, the contractor was able to move quickly to start the project. Despite the political pressure to move even more quickly, the project started with remarkable speed throughout the region. It would be hard to find a donor that could mount a major technical assistance as rapidly as ZdravReform.

As noted, the project is meant to evolve and change as it matures. Changes that come about as a result of the rolling design become part of new model interventions. This approach provides the project with a rapid-response mechanism for testing new ideas and staying abreast of the rapidly changing reform environment in the countries of Central Asia. The process can be briefly described as follows:

1. Based on considerable experience in testing reform models, the field staff can change the demonstration model or add or delete available resources to test a new idea.
2. The annual country work plans reflect strategic directions for implementation. Component activities of the country work plans are described in task orders, which specify staffing, timetables, and budgets.
3. USAID and the Abt team in Almaty negotiate the changes and agree to them.
4. The Abt field office then sends the relevant document to the Abt/Bethesda office for budgetary review. Abt/Bethesda then submits the task order to USAID/Washington for technical review and approval. When USAID raises technical or budgetary questions, Abt headquarters staff responds by coordinating with Abt field offices.

Now that the project has matured, it is important to assess the overlapping authority between the field and Washington for both USAID and the contractor. The current time horizon for the economic assistance program for Central Asia is 2002, with even less time available under the current contract to test and pilot new ideas of health care financing and delivery. It is therefore important that the current operational model requiring intensive headquarters support be altered to allow appropriate decisions to be made in the field. New contract modification and procurement procedures and streamlined communications need to be devised to move project implementation along as quickly as possible. The same observation holds for Ukraine. While the time horizon might differ there, the need to use time as effectively as possible remains an important consideration. The time lost by continuing the status quo could cost the project the loss of major impact. With USAID's current emphasis on reengineering and its substantial progress in linking its field operations electronically, the agency should be able to develop a virtual team management system that meets Washington's requirements for information but allows for both COTR and contracting officer responsibilities to be devolved to the field.

Rolling Design. An important element of the original project has been the validity of its operational methodology and its rolling design. Because of site-specific problem analysis and the ability to tailor the design of local project interventions, the demonstration sites have been able to target the issues most relevant to the reform of the financing system and the organization of health care delivery. The USAID and Abt staffs in Almaty have worked collaboratively to develop a strong sense of program vision, which their respective Washington offices have supported and endorsed to the point that they expect the project to identify many of the solutions to the problems of the health care system. The team found a similar sense of breakthrough among many of the Kazak and Kyrgyz officials working to reform the health care system. The sites visited and interviews conducted by the team in Ukraine

and Russia reinforced the sense of breakthrough. The team found a similarly upbeat attitude in Washington and among the field staff.

The identification of solutions to and breakthroughs made on some of the problems in Central Asia make replicability and sustainability more manageable as project issues. The work in Karakol, Kyrgyz Republic, is a good example of how the rolling design allowed the Kyrgyz and contract field staff to focus on the most important problems and come up with a working design that offers potential for roll out as a national program.

As part of the process of looking for ways to move the locus of operational responsibility closer to the field mission, USAID should take care not to weaken the project design's flexibility. It is the rolling design that has made the project successful, relevant, and responsive. It should be maintained at all costs. The ultimate impact of the project on the reform of the health care financing and delivery systems in Central Asia depends on continued flexibility in project design.

Respective Roles in the Next Steps. In their effort to deal with health care reform in Central Asia, both the Mission in Almaty and the Abt contract team have developed a strong, mutually supportive relationship. Despite some initial startup problems in the relationship, the Abt team has developed the necessary vision to guide the project as evidenced by the important results achieved to date. The Mission has been supportive but not directive in allowing the contract team to take the lead in developing and implementing the project. In this open environment, the contract team has performed well, with the results of its analysis of health care reform issues in Central Asia and program emphasis clearly seen in the Mission's strategic framework. The Mission has treated the contract team as professional equals and has differentiated roles to foster a sense of teamwork.

The project is, however, at an important stage in its life. As results are generated from the intensive demonstration sites (IDS), replication and sustainability issues are creating new challenges. In this setting, it is important that the Mission and the Abt team reexamine their collaborative working relationship.

Abt has worked well with counterparts at the national, oblast, and suboblast levels. Except, however, for the pharmacy privatization program and some fruitful work with national-level Kyrgyz authorities, Abt has focused on local demonstrations rather than on national-level restructuring. This is changing in that results growing out of the demonstration work have the potential for replication at the national level. To ensure replication, the Mission and the Abt team need to reexamine their respective roles in project management. The Abt team must deliver a different level of general support for national-level reforms. Specifically, despite some political recalcitrants to reform at the local level, the national-level resistance to reform is considerably more entrenched and will demand an appropriate response from the Abt team. It will also require continued strong Mission and overall U.S. government support.

The contractor should not feel that it is ceding project control by working more closely with the Mission to deal with national-level issues. Indeed, it is important that the host governments understand that the United States firmly supports the reform of the health care sector. The host

countries need to know that the United States sees health care reform as directly influencing the overall transition process. Unless the general population believes that there is a continued commitment on the part of the governments of Central Asia to maintain the social safety net, the overall transition could falter.

Lessons Learned and Information Exchanges. Already, many valuable lessons can be learned from the ZdravReform work underway throughout the region, including Central Asia. The project has been the catalyst for the exchange of information among a set of demonstrations in the Central Asian countries, though less sharing occurred among the other countries of the ZdravReform program and Central Asia. Clearly, Abt/Bethesda, USAID/Washington, each of the Abt field offices, and, probably most important, each of the regional missions need to address improvements in information exchange. A determined effort is needed to increase communication among Almaty, Kyiv, and Moscow. Staffs and counterparts should make intercountry site visits. Regional, topic-specific, technical-oriented conferences should be encouraged. In particular, lessons learned should be widely shared to increase awareness of successes and to assure those responsible for making health care reform a reality in their respective countries that they are not traveling the path alone.

B. Ukraine

After two years of activity, the ZdravReform program in Ukraine has developed a set of useful health care reform models that have been field tested in Lviv and Odessa. The project has worked at the national level to encourage health care reform policy but has achieved the clearest results at the oblast and municipal levels. The health care reform models developed by the project include various incentive payment concepts, new organization of service delivery, and information systems. All are highly relevant to Ukraine's current economic and social situation.

Ukraine's economy suffered steep declines in output and real economic activity during 1994 and 1995. Real GDP fell by approximately 23 percent in 1994 and 12 percent in 1995. Real wages, real expenditures, and gross investment all experienced similar declines. Likewise, both industrial production and agricultural output fell significantly. To counter these trends, the government is following stringent macroeconomic policies and instituting substantial structural reform to move to a market economy. The larger downward trend, however, is part of a longer-term decline that has seen millions of Ukrainian families slide into poverty since the collapse of the Soviet Union.

Given that a number of years will likely elapse before Ukraine's economy bottoms out and begins to grow at a reasonable rate, Ukraine will have little opportunity to increase public financing for the state-managed health care system. Therefore, it is important to build and expand on the systems supported under the ZdravReform program in Lviv and Odessa in order to meet at least part of the demand for quality service. New funds flowing into the health care system from user fees and savings that accrue from more efficient organization can be used to help offset the current underfunding of the health care sector.

Many national- and some local-level officials suggest that a national health insurance system is needed to fund health care adequately. Officials almost always describe the system in terms of a

payroll tax levied on firms. Since, however, a preponderance of firms are public sector firms and are not paying their bills, it is hard to see where the additional money would come from for a national health insurance system. In addition, current speculation holds that the already high tax on firms for social insurance requirements will be cut in the near future to meet the national government's economic restructuring targets.

Therefore, chances are good that the model systems developed in Lviv and Odessa offer the government the best chance for addressing at least some of the financing problems in the health care sector by applying the savings from increased efficiencies and the new funds from fees for service. When the economy begins to grow again, additional options for both public and private financing will emerge. The government cannot, however, wait until a future date to take action. It needs to look at its options today and select from those that offer the best opportunity for improving health care delivery over the short run.

The Abt field team has provided strong management of the oblast-level activity. It has also provided significant input into the policy dialogue on health care issues in Ukraine. At the same time, the Mission succeeded in elevating the health care dialogue within the context of its overall policy dialogue with the government of Ukraine. A high degree of interaction relative to project actions and issues characterizes the relationship between the Mission and the contract team. This collaboration has advanced the strategic objective of the U.S. government. The visible interest of senior Mission management in the oblast demonstration sites has given the imprimatur of the U.S. government to the health care reform effort. The involvement of the U.S. government is an important signal in a political environment where senior national-level officials are still somewhat ambivalent about the necessary structural change that must occur if the health care system is to operate efficiently and effectively in an open economic system.

As was the case in Central Asia and Russia, the time line for the ZdravReform program in Ukraine was not realistic. Reform of the health care system is a long-term process. Overcoming political, economic, and social inertia takes time. As confirmed in both Central Asia and Russia, the IDS project implementation model is an ideal approach that has allowed for experimentation at an operational level. The model has begun to produce systems that can be replicated and retested in different environments. In fact, if a breakthrough can be made at the national level, Ukrainian-tested models of health care reform will stand ready for consideration as part of a national program.

The Mission and the contractor are at a critical point in the life of the project. The first round of oblast tests is nearing completion, and the results have been promising. One senior national-level Ukrainian official noted to the evaluation team, "We have learned as much from the tests that have not gone well as we have from those that have succeeded." His implication was that the process was an important step for Ukraine.

The next phase of the project is ready to go forward. In its plan document entitled "Directions for Health Reform Strategy Development in Ukraine," the Abt team has laid out a vision for the necessary next steps. The Mission and the Abt team must, however, specify the operational steps

needed to turn the plan into an input/output model. The next steps in health care reform in Ukraine will be critical.

The Mission brings to the team an understanding of overall U.S. government goals and objectives as well as a deep insight into the U.S. government's progress in its negotiations with international lending institutions. These broader negotiations will undoubtedly shape the options available to the Ukrainians as they begin to reform their health care system. The Abt team, of course, brings to the team its considerable knowledge of the Ukrainian health care system as it currently functions as well as a sensitivity to what is feasible. Properly structured, a team approach to defining and implementing the next phase of health care reform could be a win/win situation for the Mission, Abt, and, most important, the U.S. government and the Ukrainian people.

C. Russia

The ZdravReform program in Russia developed differently from the programs in Ukraine and Central Asia. Russia is a large, complex, and diverse country. By the time the project got underway in 1994, a good-sized USAID Mission was already on the ground and the Mission exercised a significant level of control over the project. Further, health care reform issues appeared to be central to the Russia Mission's policy dialogue from the earliest days.

Despite differences in ZdravReform's Russia program, much of what has been noted about the programs in Central Asia and Ukraine also applies to Russia.

- C The links between reform of the health care sector and the success of overall economic transition are apparent in Russia.
- C The project design as currently configured works exceptionally well. It concentrates activities at the oblast or local level to test various reform interventions and maintains flexibility in programming experiments.
- C Shifting operational control of the project to the Mission, while a protracted and difficult process, allowed for efficient use of time and speedy implementation.

The size of both Russia and the ZdravReform program gave the reform effort some distinctive qualities. It accounted for over 80 important pilot projects, made 38 grants to test additional reform interventions, and contracted with more than 100 Russian technical experts to design, implement, and provide technical assistance to subprojects serving communities with over 26 million people.

Another factor that shaped the Russia program was the deeply held sense among the Russian counterparts that the ZdravReform program was part of a much larger and longer-term process. Health care reform has been part of the health care sector agenda in Russia since the mid-1980s. Many professionals and health care providers have been working on health care reform ideas, programs, and projects for at least that long and, as a result, are primed to use technical help efficiently and productively.

Added to the history of work on health care reform is the high level of education among the counterparts involved in the project. The result is an ideal environment in which to take advantage of technical assistance, training, study tours, and small grants to test new ideas and reforms. One of the evaluation team's major conclusions was that project investments in technical assistance and training yielded an exceptionally high return. In most cases, the team found that grant projects and activities planned for 12 to 18 months at the various pilot sites required only six to eight months for completion. Many of the counterparts were ready to move to the next phase of a program or to entirely new programs if such programs were in place.

On many occasions, Russian counterparts noted to the evaluation team that they did not differentiate among technical assistance, training, grant help, or even study tours. They said time and time again that all of these inputs were helping them see things differently and make the changes necessary so that they could continue to provide health care services to the public. Counterparts evidenced a strong sense of the need to maintain the social contract and recognized that health care reform was essential to keep service flowing through the health care system.

It was clear that Russian health care providers' attitude about the importance of continuing the long-term reform process increases the likely sustainability of the ZdravReform effort. The USAID Mission, however, has a responsibility to find a way under one of its current projects or programs to continue its contact with the pilot sites and grantees. The potential for more and deeper reform is great, and all counterparts seemed willing to further the effort. It would be a serious loss to the reform process in Russia if someone does not continue to take advantage of the group of dedicated professionals ready to solve some of the most serious social problems facing Russia.

The Mission proposes to disseminate two CD-ROMs developed under the ZdravReform project. One is an electronic medical library that will contain over 400 articles on "best practices." The second, developed and funded by USAID/Washington, will contain over 200 documents developed under the ZdravReform program and will be an important step in maintaining the network of people working on health care reform. Yet, more needs to be done to support the sustainability of the overall reform effort and to keep U.S. input vital to the process.

Perhaps the most vexing problem faced by the ZdravReform program in Russia was the conflict surrounding the program's early design and implementation. A chronology of the various problems and events are laid out in Annex I. In hindsight, the technical problems that sparked the conflict do not seem particularly compelling, particularly since the programs in Ukraine and Central Asia also faced many of the same problems and were able to work them out without a major contract modification. Further, the project came to rely on more Russian and fewer U.S. technical advisers. Finally, the project's management locus switched from Washington to Moscow. All of these adjustments contributed to the success of the project. What is not clear is why the adjustments engendered such conflict initially between the Mission and USAID/Washington, Abt/Moscow, and Abt/Bethesda and continued with Abt/Bethesda throughout the entire contract period. It was the consensus among the evaluators that the conflict reflected poorly on all and could have been easily averted.

D. Cross-Regional Observations and Recommendations

The USAID Regional Mission for Central Asia asked the evaluation team to identify possible activities or issues in Ukraine and Russia that might be relevant learning opportunities or alternative approaches for the ZdravReform program in Central Asia. In fact, many “innovative approaches” were observed in all regions of the program. As a result, the evaluation team has recommended greater technical information sharing and coordination among field staff and USAID, particularly on major health care reform issues.

Pharmaceutical Rationalization/Security. Central Asia, Russia, and Ukraine are experiencing severe shortages in pharmaceutical supplies. With declining health budgets, public facilities are no longer supplying patients with essential drugs. Creating a sustainable pharmaceutical delivery system is critical to controlling health costs, preserving patient access to necessary pharmaceuticals, and solidifying financial and payment reforms.

C In Kazakstan, ZdravReform has approached the critical drug problem by

- (1) assisting with the privatization and management overhaul of the state-run Farmatsiya;
- (2) providing valuable assistance to the Ministry of Health in preparing a national drug list. This effort provided the basis for further work in rationalizing drug use, such as the drug formularies; and
- (3) introducing rational management of pharmaceuticals in pilot facilities by putting formularies in facilities and providing up-to-date pharmaceutical information to practitioners. The program is also developing a policy for drug reimbursement. These reforms have been integrated into the comprehensive demonstration sites in Kazakstan.

C In Russia, a separate USAID-funded program called the Rational Pharmaceutical Management (RPM) program established formularies, drug information systems, and reformed provider prescribing practices. Counterparts in Russia expressed great interest in controlling health care costs by streamlining pharmaceutical management.

While the pharmaceutical activity is still in the early implementation stage, ZdravReform and USAID contractors will track the impact of the restructuring on consumer access to drugs. The experiences with pharmacy rationalization should be shared widely with Russian, Kyrgyz, and Ukrainian counterparts and may be considered for replication in these sites.

Promotion of Family Medicine and Curricula Development. All elements of the ZdravReform program are attempting to redirect health care sector resources from overly specialized, hospital-based care to a cost-effective, quality primary care delivery system. Training programs were developed to reorient specialists and generalists to provide family medicine at newly created family group practices.

- C In Russia, Ukraine, Kazakstan, and the Kyrgyz Republic, ZdravReform has assisted local medical institutes in developing (1) short-term clinical refresher programs and (2) academic specialty programs in family medicine. In addition, family physician licensing and certification procedures are being developed in the Kyrgyz Republic and Tomsk, Russia. These procedures may be of interest to Ukraine, whose MOH is defining the legal status of family practice.

As curricula and training programs were developed at different times and by various consultants and institutional bodies, it would have been useful to examine the various materials for consistency and practicability for working physicians. The clinical refresher programs were, of necessity, intensive and didactic. However, several programs were planning to feature an “on-the-job” component that would allow family medicine trainees to be taught clinical skills at family group practices through the treatment of presenting patients. Several counterparts have developed innovative strategies for promoting primary care and continued information sharing among physicians.

- C In Semipalatinsk, family medicine trainees will be allowed to practice their newly acquired skills in urban primary care micropolyclinics on an internship or rotation.
- C In Lviv, Ukraine, through the family medicine program at City Hospital #1, resident specialty doctors are rotated periodically through polyclinics, enabling them to treat patients in an ambulatory setting. This coordinated approach between primary and secondary treatment will result in greater continuity of care for the patient, doctors more knowledgeable about a patient’s health status, and more efficient use of hospital beds and services.

The evaluation team recognized the value of developing medical curricula and clinical practices training as part of the restructuring of the health care delivery system. Given the limited time remaining on the project, however, the contractor should remain focused on payment and service delivery reform. Therefore, in view of the massive task of reforming the medical education system and clinical training for family medicine in the NIS, it would be best if ZdravReform continued activities supporting these endeavors by engaging and collaborating with medical academic centers and outside professional associations, including those funded by USAID and operating in the NIS.

Building Counterpart Capacity. Supporting innovative NIS partners, including administrators, government officials, and health care professionals, and giving them the necessary tools to continue the work is a chief element in ensuring sustainable health care reform once USAID funding has concluded. To date, the ZdravReform has supported local leaders and “targets of opportunity” through technical assistance, training, and grants.

- C In Russia, ZdravReform was directed to use Russian partners as technical consultants and to reimburse them for specific technical activities and training of others. In addition, a waiver was granted to support governmental organizations. It appeared that these strategies were effective in promoting counterpart buy-in to activities. It seemed to the evaluation team that the Russians truly considered the activities as theirs and that Americans were perceived

as true partners and not as donors, which was critical to the success of the program in Russia.

- C In the Kyrgyz Republic, the program has developed the “health manager,” who will assist with the management and administration of the newly created family group practices. Health managers will be responsible for maintaining all financial and health status data as well as data on physician performance and will serve as a resource for all decision making within the practice.

The evaluation team recommends that both Ukraine and Central Asia consider directing more resources and attention to grooming NIS counterparts who are technically able to promote financing and service delivery reform in additional areas after the project is completed. These counterparts will be the future health reform leaders in the NIS.

Consumer Participation. While the ZdravReform program has been successful in beginning to change the mindsets of providers and administrators, a critical element is to increase the involvement of consumers in their own health care. The evaluation team found that if the public is to continue supporting economic transition while suffering financial hardship and social dislocation, consumers must also begin to see tangible benefits from these reforms either through increased choice and/or more responsive service.

- C In the Kyrgyz Republic, the voluntary enrollment campaign for the family group practices is a major example of galvanizing public attention to the importance of the patient-physician relationship and stimulating consumer choice. In Issyk-Kul oblast, individuals selected a family doctor from a group of competing FGPs. For the first time, they were allowed some choice in health care. Residents were also informed about the value of primary care and preventive services. While ZdravReform could have implemented the family group practice enrollment on a mandatory, assignment basis with the full approval of the MOH of the Kyrgyz Republic, it decided that the value of giving residents the choice of provider as a first step for taking responsibility for health care would outweigh the convenience of a prescriptive approach.
- C In Semipalatinsk, the Mandatory Health Insurance Fund has widely publicized a “patient hotline” that patients can call to report maltreatment on the part of physicians or facilities. A complaint automatically triggers a case quality review by the QA department of the MHIF. In Semipalatinsk, a community awareness campaign to educate residents about the benefits of family group practices forming “micropolyclinics” is planned; in Dzhezkasgan, an enrollment campaign for FGPs will take place.

In addition, the system of informal “envelope payments” to providers as inducements for preferential treatment needs to be addressed as much from the patient side as from the provider side. While NIS governments have committed to providing most health care free of charge to citizens, the current budget crisis demonstrates a need for new funding streams to sustain the health care sector. “User fees” for selected services are a potential source of revenue. However, many patients and providers prefer to pay informally and preserve the direct relationship; unfortunately, this prevents any

reinvestment in the public health care sector. User fees need to become legitimized within the health care sector while patients paying user fees should realize that paying for health care “above the table” entitles them to certain rights and privileges as a client and patient. Legitimizing user fees could assist in the development of a more equitable relationship between patients and providers, which is a critical element in a civil society. Since these issues are common to the NIS region, collaboration on solutions would be beneficial.

Quality Assurance, Standards of Practice. As mentioned elsewhere, the field technical staff should collaborate where possible on NIS-wide issues, especially those of quality assurance, clinical practices, and medical effectiveness. As in the case of medical curricula, ZdravReform may want to address these issues in partnership with medical academic centers and U.S. professional associations.

While local counterparts’ adherence to the Soviet clinical protocols and guidelines known as “prekazy” or “norms” varies widely, the evaluation team found that these rigid, norm-based, quantitative standards of care dictating length of hospital stays, treatment, medications, and even administrative procedures could seriously undermine the positive impact of payment and service delivery reforms undertaken by the program.

- C In the Siberian GFA, some of the quality assurance initiatives involve the use of medical-economic standards (MES), which specify the minimum diagnostic and curative procedures that must be undertaken per diagnosed condition. The standards measure the process of treatment and patient outcome and are used to reimburse providers and facilities. The concern with the MES as quality indicators is that they tend to require physicians to follow rigid, perhaps outdated procedures (similar to prekazy or norms) rather than allowing the physician the autonomy to practice as the patient’s condition might dictate.
- C Working with CDC, ZdravReform has managed to engage the Kazakstan MOH on the issue of unnecessary but mandated hospital stays and has convinced MOH authorities to amend prekazy governing treatment for hepatitis A and STDs, which will result in shorter lengths of stay and increased services provided on an outpatient basis. In addition, the Central Asia program has conducted literature searches on certain outdated treatments still used in the NIS, which empirically demonstrate to physicians the ineffectiveness of certain treatments.
- C In Lviv, Ukraine, “clinical pathways” encouraging efficient and quality treatment for high-volume diagnoses are being tested, and providers are planning to institute pathways as a substitute for “norms.”

Providers at Risk. Throughout the program, a certain feature has been to establish independent family group practices that will in the future be financially responsible for patient care. As mentioned elsewhere in the report, the nature, definition, and extent of risk bearing and risk sharing between payors and providers should be monitored, discussed, and refined as the program continues. The team also recommends that cross-regional information exchange between sites in Russia, Central Asia, and Ukraine should continue and be expanded as need arises. As risk-sharing

arrangements continue to be explored, the team urges careful consideration of the appropriate balance between payor and provider protections, such as risk corridors, the MHI acting as a reinsurer, cross-practice pooling, withholds, or other stop-loss protections.

E. Cross-Regional Information Sharing and Lessons Learned

ZdravReform has developed a variety of written “products” that serve as educational and informational resources for counterparts and document reform activities in each country to date. In addition to country- and site-specific documents, the USAID/Washington office has been managing and developing activities to enhance health care reform knowledge and project lessons learned on a regionwide basis. The current and planned cross-regional activities to date include the following:

- C A regional conference was held in Almaty, Kazakstan, in December 1995. Counterparts from Central Asia, Russia, and Ukraine attended, presented preliminary findings from their experiments, and participated in networking and smaller working group discussions. Participants commented on the value of sharing their experiences through this forum.
- C A CD-ROM containing all products produced under the ZdravReform program will be disseminated to NIS counterparts. In light of the lack of CD-ROM drives in the ZdravReform computer procurements, USAID/Washington will also provide diskette copies of the CD-ROM for counterparts who may not have access to a CD-ROM drive.
- C In addition to ensuring that all country- and site-specific publications are available to health care reformers throughout the NIS, USAID/Washington is funding ZdravReform case studies and lessons learned papers that synthesize experiences in provider payment, primary care, and integrated service delivery from all ZdravReform sites.
- C ZdravReform is developing a series of cross-regional, focused study tours that will enable NIS health professionals to visit reform sites in the NIS and build working relationships with their counterparts in Russia, Ukraine, and Central Asia.
- C This evaluation provides in one summary document information about the range of activities undertaken by the ZdravReform project and will provide a useful reference for those interested in replicating activities. In addition, the evaluation team was composed of highly regarded technical experts and a former USAID senior official who have unanimously endorsed the importance of health care reform in the NIS and as a core component of the USAID portfolio that incorporates economic development, democracy, and social sector restructuring dimensions.

III. RECOMMENDATIONS

The following recommendations are drawn from the recommendations outlined in the three regional annexes of the evaluation and represent the evaluation's most important findings. In addition, the recommendations listed here grew out of more than one of the regional programs and therefore have regionwide relevance.

A. Project Design

1. In Russia, Ukraine, and Central Asia, health care reform should remain an important part of the U.S. Mission's policy dialogue process. Health care reform is critical to the success of the overall economic transition underway in all the participating countries and plays a vital supporting role in the ENI Bureau's strategic objectives in the area of economic transition and democratic liberalization.
2. The work under ZdravReform has been highly successful in technical terms and should be continued. In Central Asia and Ukraine, the Abt contract should be extended for the final two years of the project. In Russia, the Mission should ensure that some form of technical help continues to flow to the more than 80 pilot test sites and 38 small grantees that cooperated on the project. From its inception, USAID's work on health care reform has been couched in the rhetoric of a short-term effort. Health care reform is a long-term process for the people of the NIS and deserves to be identified as such.
3. The design of the next stage of USAID's involvement in the health care reform process in Russia, Ukraine, and Central Asia should specifically take into account how to share experiences, results, and new ideas among the countries and projects working on health care reform. Too little sharing occurred in the first phase of the project.
4. Much of the work already completed and ongoing is of exceptionally high quality. If it were public, it would demonstrate to the people of the region that their governments and others are working hard on one of the most vexing problems they face: continued access to high-quality health care. A public affairs effort should be undertaken in collaboration with counterparts in all three regions to get the message out to the general public.

B. Project Management

1. To the maximum extent feasible under the present management/contracting arrangement, more of the project management functions should shift from Washington/Bethesda to Almaty and Kyiv, particularly those that will speed project implementation. Where authorities and responsibilities need to be shared, they should be restructured around new concepts of teamwork that take into account the need to work in virtual teams.
2. In close collaboration with the Missions, USAID/Washington has taken the initiative to develop and fund cross-regional activities and information sharing. These activities should be continued

and additional funding provided to ensure that valuable lessons learned and innovative approaches can be disseminated.

3. The ZdravReform program's rolling design has been a highly efficient management tool. All follow-on work should maintain a similar level of flexibility to ensure program responsiveness to the rapidly evolving political and economic environment of the NIS.
4. As the project got underway, a number of management conflicts developed in each of the three regions' programs. To some extent, the conflicts impeded the implementation process. Disagreements extended from basic approaches to health care reform such as national versus local interventions, to the role of health care reform in the Mission's policy agenda, to staff issues and the overall speed of startup. While the conflicts have been settled, they deserve a high level of attention if they resurface so as not to impede progress. Either USAID or Abt could resolve the conflicts, although both parties should ideally participate in conflict resolution.

C. Clinical Issues

1. Clinical training was not part of the project's original intent. In each of the regional programs, however, some aspect of clinical training or retraining proved to be necessary to meet health care reform objectives. Clinical training/retraining needs to be continued through new project activity; the project should seek partnerships with outside sources of medical technical assistance such as the AMA, the American College of Family Practitioners, or other available in-country technical help.
2. The Soviet prekazy and medical economic standards systems that mandate care interventions per diagnosis (including length of hospital stay, procedures, etc.) prevail in all three regions and continue to inhibit the new family practitioners in their treatment of patients. They also undercut many attempts to treat patients in a less costly outpatient setting. In addition, all three regions rely on old Soviet models of quality assurance. In Russia, Ukraine, and Central Asia, quality assurance tends to focus on policing providers in their adherence to strict, process-oriented standards. Further assistance in quality assurance is needed and should focus on patient outcomes. Again, this effort would benefit from sharing examples of successful approaches used in the three regions.

D. Payment Methods

1. Across the three regions, declining national and state budgets have been a chief obstacle to reform of the health care sector. In addition, the taxes collected to fund the provision of health care have been inadequate. Indeed, taxes are the principle resource for the various national and oblast health insurance funds that have been set up to funnel money into the health care sector. At the same time, under-the-table payments remain a feature of the overall health care provision systems in all three regions. This reality needs to be addressed. These payments should be the subject of an intensified policy dialogue to legitimize them, either through limited private practice or user fees. If ignored, they could undermine other health care financing reforms.

2. The project should continue to test the primary payment models that have been at the core of the project. These include
 - C global budgets and case-based reimbursement for hospitals;
 - C partial capitation for primary care and some adjustments for tests and outpatient specialty services on a fee schedule;
 - C costing of user fees for certain services; and
 - C costing exercises to see what services could be covered under a basic benefits package (mainly an inpatient or outpatient decision).

E. Information Management

While the work on computerization and information management systems has been crucial to much of the project's reform work, the job is not complete. One problem in need of attention is the tendency to computerize the existing work flow. Follow-on assistance should help the test sites understand how better to reengineer work flow to optimize computer use. Counterparts need to learn how to determine organizational goals and then organize around them.

ANNEX B

CENTRAL ASIA

I. OVERVIEW

The Central Asian countries (total population 60 million), like all the former Soviet states, are experiencing extreme hardships resulting from the dissolution of the Soviet command economy and administrative system. Unlike the Baltics and other western regions, the Central Asian republics were net beneficiaries of the Soviet system with regard to capital investment, budgetary support, and provision of essential equipment, commodities, and skills. Even today, the governments of Kazakhstan and the Kyrgyz Republic closely follow Russia's experiences and activities with respect to the political, economic, and social sectors as possible models for emulation (or avoidance). In the area of health care reform, Kazak and Kyrgyz counterparts were highly interested in studying Russia's activities, particularly the regional Siberian health care reforms and the national-level mandatory health insurance (MHI) program.

With the advent of the new independent governments, all economic sectors, including the social protection and health care sectors, have dramatically reduced their funding levels (approximately 3 percent of GDP is currently spent on health in contrast to approximately 6 percent before 1992). Further, the health care sectors of Central Asia evidence all the structural inefficiencies (as well as the benefits of universal access) that are the hallmarks of the former Soviet health care system. These inefficiencies include a concentration of financing and delivery of care at the hospital level, overcapacity of hospital facilities, centralized budgeting and financing and a top-down approach to administration, lack of incentives for facilities and providers to ensure quality and responsiveness to consumers, and lack of patient choice and responsibility for health care.

At the same time, the region can point to a remarkable wealth of natural resources. In particular, Kazakhstan's oil reserves are calculated to be as large as those of Saudi Arabia. The anticipation of future economic expansion has been somewhat of an obstacle to undertaking a number of systemic economic reforms, especially at the national level. Indeed, hopes are pinned on soon-to-materialize wealth as the solution to every structural inefficiency and breakdown. In the Kyrgyz Republic, natural resources are fewer and the country is experiencing economic hardships and social dislocation from the breakdown of its agricultural system. The republic has embraced structural reform of the health care system, developed a "20-year" MANAS plan for health care, and is strategically relying on international donors for assistance. Both Kazak and Kyrgyz counterparts are committed to preserving the best elements of the former Soviet system, which include the guarantee of health care for all and the maintenance of the social safety net to support the vulnerable (aged, pensioners, veterans, children) during the difficult transition. The commitment to maintaining the social contract for all citizens is evident among providers and local and national government officials and has continued despite reduced funding for health care.

Both countries point to severe underfunding, not inefficient structures, as the major problem in the health care sector. For example, during the past several years, national funding allocated to health

has declined precipitously. This year, the little funding available for health care has been directed to provider salaries. Even so, many health care providers interviewed by the evaluation team had not been paid (or had been paid only in goods) during the past six months of 1996. These dedicated physicians have continued to provide needed services to the public in the absence of both salaries and adequate supplies of medicine, equipment, and material. Both Kazakhstan and the Kyrgyz Republic are trying to use health care reform to obtain new sources of funding for the health care sector, though they are beginning to acknowledge that improving “incentives” and redirecting resources in the system will help them use existing resources more efficiently.

In Central Asia, ZdravReform has evolved over the past three years from the original design developed under the contract and the Request for Proposal (RFP) process to a program specifically centered on the needs of the Central Asia region and clearly in line with Mission priorities. In the program’s early days, the original design, management structures, and minimal level of USAID involvement somewhat inhibited development of ZdravReform.

In many ways, USAID capacity and assumptions about reform in the New Independent States (NIS) guided program development. At the time the program was designed, the USAID presence in the field was still limited, and newly established Missions had few technical staff on the ground to oversee the development of complex country programs. In addition, USAID was obliged to ensure that programs were closely coordinated with the State Department and the Office of the Coordinator for U.S. Assistance to the NIS (S/NIS/C) and to obtain clearance from the office for its programs. Given the high visibility of the program (and of USAID assistance to the NIS in general) within Congress, the State Department, and the Executive Office, USAID in Washington necessarily assumed both informational and managerial responsibilities for NIS programs to a level that exceeded such responsibilities in USAID programs in other parts of the world. Time was also a critical factor. The NIS programs were expected to operate for five to eight years. The ambitious Health Care Financing and Service Delivery Reform (HCFSDR) program strategy included the rapid assessment and implementation of technical assistance to achieve complex and systemic reform within five years.

On the technical side, early assessment visits to the NIS, especially to Russia and Ukraine, revealed that market-oriented activities as envisaged under the HCFSDR activity should emphasize privatization of the health care sector and introduction of health insurance and private payment models. While the contract mentions service delivery reforms, practice clearly emphasizes promotion of the development of private, entrepreneurial health care providers and insurers and the design of informational (including quality) systems to support them. Moreover, privatization and decentralization in all sectors in the NIS have been a central assumption of the assistance program.

Abt Associates spent 1994 designing the Central Asia program and setting up field offices. The program benefited from earlier contacts with regional counterparts under the Health Financing and Sustainability (HFS) Project. ENI funded HFS to initiate health planning and training activities in the region as quickly as possible. Several individuals who worked on the HFS Project and, later, under the new ZdravReform contract were instrumental in identifying key areas for possible intensive demonstration sites (IDS). Abt is currently working in at least three of these HFS sites in

Kazakstan and the Kyrgyz Republic. Uzbekistan, originally targeted for assistance, has not seemed ready for reform in the health care sector; until lately, ZdravReform has had minimal impact there.

Abt established a regional office in Almaty in mid-spring 1994. From that point, the Central Asia program faced a number of sometimes conflicting challenges and mandates. As in the other parts of the country program under this contract, management authority was centralized in Washington (USAID) and Bethesda (Abt). While such concentration was necessary during startup and initial implementation, the staff in the field perceived that it later hampered field operations. The Abt bureaucracy complicated personnel matters, for example. Moreover, the program had to respond to Mission priorities, which called for quick results and an emphasis on privatization of the health care sector. In addition, the Abt field staff was learning that the Central Asia environment required more intensive, longer-term technical assistance than originally foreseen by the contract. In some cases, different types of assistance, including a fundamental restructuring of the system, was required.

Several design elements caused tensions in the development of the program. The contract's emphasis on rapidly selecting and committing the lion's share of country resources (70 percent) to intensive demonstration sites did not promote the flexible use of resources and meant a delay in responding to several opportunities to support newly discovered "hotbeds" of reform. In addition, the original design did not specify certain key elements needed to improve health care in Central Asia, such as addressing the absence of a working pharmaceutical distribution and procurement sector and the promotion of primary care. With these omissions subsequently corrected, the Central Asia program has benefited from a rolling design that capitalizes on targets of opportunity and addresses missing elements.

With the approval of the Kazakstan Ministry of Health (MOH), the ZdravReform Kazakstan program has focused on two major areas: privatization of the state-owned pharmaceutical distribution and retail system (Farmatsiya) and development of supportive parallel systems (drug information systems, essential drug lists, facility-based formularies, and targeted assistance to newly privatized retail pharmacies); and technical assistance for oblast-level reform of financing, delivery, and quality control of health care. The pharmaceutical activity has been based in Almaty city and oblast and in Shymkent oblast and is beginning in Dzhezkasgan and Semipalatinsk oblasts. ZdravReform's original IDS located in Shymkent City, South Kazakstan, has been closed. Smaller comprehensive demonstration sites have targeted technical assistance to Semipalatinsk and Dzhezkasgan oblasts in the areas described below.

In both Kazakstan and the Kyrgyz Republic, ZdravReform is providing a comprehensive package of technical assistance in finance and service delivery through local and U.S.-based consultants. The assistance is intended to (1) advise on legislation and health policy at the national and oblast levels; (2) advise on health insurance and pooling of funds; (3) develop alternative provider payment methods; (4) promote facility restructuring by creating family group practices, emphasizing outpatient care, and rationalizing unneeded facilities; (5) introduce quality and management information systems to support payment of services and patient tracking; (6) emphasize consumer choice and consumer responsibility for health care; (7) strengthen family medicine as a specialty and

improve the clinical and counseling skills of physicians; and (8) address issues of medical effectiveness of treatments. ZdravReform/Almaty also offers a small grants program to enhance the capability of family group practices by providing the practices with limited support for minor facility renovations and essential medical equipment. Several nongovernmental family practice associations have formed to channel the grants to individual family group practices and to serve as advocates and resources for physician members.

The program in the Kyrgyz Republic is concentrated at the IDS in Karakol, Issyk-kul oblast. The Kyrgyz Republic Ministry of Health (MOH) has designated Issyk-kul as the pilot oblast for health reform activities and has introduced a Mandatory Health Insurance program administered by the Mandatory Health Insurance Fund (in Issyk-kul, this entity is merged with the oblast health department) to pay for health care services. In the beginning, ZdravReform focused on Karakol city and two additional rayons (oblast subdivisions); the program is currently active at an oblastwide level. ZdravReform is working with local counterparts to transform the primary health care system in Issyk-kul oblast by establishing family group practices that will provide primary health care to patients who enroll in a practice. The family group practices are reimbursed under a per capita payment system, which rewards physicians based on the number of patients enrolled and treated and the quality of care provided. The technical assistance package is described above. The World Bank intends to roll out this IDS model in cooperation with ZdravReform on a nationwide basis under the new World Bank health care sector loan. ZdravReform will also coordinate with the Kyrgyz Republic government's national health care reform MANAS Project in designing a family medicine curriculum and program for the universities.

II. HEALTH CARE FINANCING—KAZAKSTAN AND THE KYRGYZ REPUBLIC

A. Background

Kazakstan and the Kyrgyz Republic share a number of common elements that affect the context within which health care reform efforts have functioned to date.

1. Favorable Elements

- C Both nations have long practiced and remain firmly committed to universal access to health care, which is also the basis for their health care reform efforts.
- C Since the breakup of the Soviet Union, both nations have passed legislation that supports mandatory health insurance (MHI). While enrollment is intended to be universal, the payors of premiums are primarily employers, who are expected to contribute on the basis of payroll (3.5 percent in Kazakstan). The national and local governments will contribute on behalf of the unemployed, the unemployable, children, and special classes such as veterans.
- C While several factors worked to impel passage of the legislation, it is unlikely that any factor was as strong as the recognition that general tax revenues could no longer yield the resources needed to support the health care sector.
- C The passage of mandatory health insurance legislation provided an opportunity for creating payment incentives designed to modify users' consumption of services, provider productivity and organization, the relative emphasis on alternative levels of health care delivery, and the structures through which health care is delivered.
- C Since independence, both nations have demonstrated a high level of interest in undertaking multiple demonstrations of alternative approaches to the financing and organization of the health care sector.

2. Unfavorable Elements

- C Both nations are characterized by health care systems with a long history of inefficiencies and centralized planning; chapters-based budgeting, a residual from the Soviet period, in which incentives to maintain excess hospital capacity have been especially strong; substantial overbedding, with high admission rates and long lengths of stay; and disproportionately few physicians (approximately 20 percent of all physicians) devoted to primary rather than hospital-based care.
- C Hospital costs dominate the health care budgets of both countries, consuming approximately 65 to 70 percent of resources available to the health care sector. Hospital costs in the two nations are nearly 150 percent higher than those in the United States and Western Europe (although far lower in absolute terms).

- C In comparison with patterns in Western Europe and North America, health care expenditures and the health care delivery system in the two nations form an inverted pyramid in which health promotion and primary and ambulatory care are grossly underfunded while hospital-based care and specialty-dominated polyclinics dominate.
- C The expenditure patterns flow largely from the hierarchical training history of specialty versus generalist/primary care physicians in the Soviet Union. Primary care providers have historically received substantially less training than either their Western counterparts or Soviet specialists. Therefore, their professional status, income levels, and capacity to provide successful treatment have been limited. As a result, primary providers are responsible for high rates of referral to specialty polyclinics and hospitals.
- C In addition, both countries have inherited prekazy—clinical standards defining conditions of care—from the Soviet system. Despite major exceptions, too many prekazy lack outcome-based or other scientific underpinnings to serve even notionally as guides to best medical practices. The scope and range of prekazy is staggering and, for example, extend to a several-month hospitalization requirement for a torn Achilles tendon, identifying conditions under which specialist referrals must be made, and so on. Even though a structure is in place for updating the prekazy, interviewees noted that the structure is used too infrequently to reflect changing medical awareness, advances, and techniques. Given strict compliance reviews and the threat of disciplinary actions (including license revocation) for noncompliance, prekazy carry substantial force in controlling the practice of medicine.
- C Since independence, the proportion of gross domestic product (GDP) devoted to the health care sector has not only fallen sharply, but, in both Kazakstan and the Kyrgyz Republic, GDP has dropped by as much as 50 percent. Consequently, real health care resources have been reduced by substantially more than half since 1990.
- C Health status indicators—morbidity, mortality, infant and maternal death rates, and life expectancy—have all deteriorated significantly following nationhood.

B. Hospital Financing/Payment Policy Efforts

Especially in hospitals and polyclinics, the separation of budgets from service, which is a major consequence of the chapters system, has obscured the real costs of health care. Moreover, chapters-based budgets did not separate inpatient from outpatient care while hospital payments did not reflect payment for services rendered to patients. In both Kazakstan and the Kyrgyz Republic, development and implementation of an effective product-oriented cost-accounting system has been pivotal to health care reform.

The several major payment approaches under consideration included payment of a daily rate (per diem), an approach used for a time in Dzhezkasgan, Kazakstan; payment of actual costs; and diagnostic-related groups (DRG), the structure used by the U.S. Medicare program. Of special

import in the context of reforming the former Soviet system, the fatal flaw in the first two approaches is that, unlike the DRG system, neither provides incentives to control costs.

The Abt-supported ZdravReform step-down costing method adopted by the IDSs in both nations (in Dzhezkasgan and Semipalatinsk oblasts in Kazakhstan and in Issyk-kul oblast in the Kyrgyz Republic) is a modified version of the U.S. Medicare DRG payment system.

C Using historic discharge data, the cost-accounting system splits inpatient from outpatient services; collects each hospital's discharges into diagnostic- (or, if necessary, clinical department) related groups; divides resources in each department by the number of discharges of that department to establish a department-level average cost; orders the set of hospital departments' average cost to establish relative weights; and, then, using total resources consumed for inpatient care, calculates a cost/price per case by diagnostic group or clinical department.

To establish diagnostic-based per cost amounts for analytic and reimbursement purposes, Abt provided technical assistance to the IDS sites in both nations for coding and grouping the recent experience of the local hospitals. The effort called for establishing a methodology, oversight of computer programmers, training the trainers of site coders and the data entry staff, and development of the necessary forms and templates for analysis. Conduct of the programming, coding, and data entry, however, was (and continues to be) the responsibility of nationals in the two countries.

The analytic products of these activities allow IDS-level identification of per hospital costs and average cross-hospital per case costs and an assessment of individual hospitals' comparative production efficiency. In turn, the Ministry of Health (MOH), oblast health departments, rayons (suboblast government units similar to counties), and individual hospitals have used the information to explore methods for increasing efficiency. In addition, the MOH and the MHI Fund have used the information to establish hospital per case base reimbursement rates.

From the perspective of hospital payment reform, the most important aspect of these activities is that mandatory health insurance funds in both countries' IDSs are using simplified, experience-based cost-accounting systems to establish hospital reimbursement policies and per case payment amounts, both of which provide the basis for provider incentives. Inherent in these incentives are cost controls, enhanced efficiency, and the potential for future competition.

Regarding sustainability and replicability, it is worth noting that the approach to payment reform underlies the World Bank's decision to support similar hospital reform roll out at two additional Kyrgyz oblasts, Bishkek and Chui. Further, Kazak sites outside the IDSs are voluntarily adopting the payment approach as the basis for MHI funds.

Among the important spillover effects is the payment approach's conversion into ongoing management information systems (MIS), an undertaking initiated with historical data as a means of establishing baselines. As additional computerization becomes available and more hospitals develop the capacity to enter data, the available information will approximate real-time experience.

Not only do the information systems permit the efficient filing of periodic hospital reports required by the central governments (which to date have maintained such process-oriented data as bed days, occupancy rates, numbers of meals served, etc.), but, more important for reform, they also allow examination of resource utilization, costs, and changes in production functions within and between facilities now and in the future. Data on resource utilization, costs, and changes will provide the basis for both competition and analyses of outcomes by diagnosis and service category. These data and outcomes will shape quality assurance processes and will be a powerful advance in the oversight of care. They will form an in-country scientific base for enhancing the practice of medicine.

1. Kyrgyz Republic

In the Kyrgyz Republic, Abt has played a major role in helping to lead the search for appropriate reform options. In particular, Abt and its associated personnel have conducted an ongoing health care reform seminar with the nation's political, community, and medical leaders. Yet, Abt—under ZdravReform—has done more than simply conduct an ongoing dialogue in the abstract. As exploration has moved to decision, ZdravReform has provided technical assistance in implementing reform approaches selected in concert with affected parties, including the Ministry of Health, the MHI Fund, hospital leaders, and others at the national, oblast, IDS, and local levels.

The reforms initiated in the Kyrgyz Republic before Abt's involvement were limited. The most notable reform was passage of the Mandatory Health Insurance Law and the Health Protection Act (HPA), both of 1992. In significant part, the purpose of the HPA was to remove sole responsibility for funding of the health care sector from the central (federal) government. With a delay in implementation of the HPA, Abt stepped in to help speed implementation of the act along with a demonstration of related delivery system reforms in Issyk-kul oblast. As a result, Abt has enjoyed a rare opportunity to help design a reform and demonstration structure virtually “from the ground up.”

Abt's technical assistance activities have included development with in-country partners of plans for rationalization of the substantially overbedded hospital sector. In the Issyk-kul oblast IDS, the rationalization process achieved a major and dramatic success: closure of the Karakol municipal hospital, which evidenced personnel redundancy as well as overbedding. This closure represents a difficult decision on the part of the city political leaders dedicated to and politically invested in reform. The municipal hospital was the only such facility under local government control. As the direct result of the closure, residents of Karakol now depend for hospitalization on facilities that operate under budgets and pressures from other levels of government.

While elimination of excess capacity is one aspect of facility rationalization, it has been matched by efforts to strengthen the management capacity of the remaining facilities. Considerable effort has gone into delivering management training to hospital administrators. In addition to developing the cost-accounting structure that undergirds DRG-based reimbursement—itsself an important management tool at the individual hospital level—Abt has provided related technical assistance and training in clinical information systems, planning, and the consequences of and opportunities associated with newly developing facility-level managerial autonomy. These are important building

blocks for the future as centralized control, chapters budgeting, automatic case referrals, and noncompetition give way to reform.

With intentional exceptions for small, remote rural providers whose preservation is socially desirable regardless of costs, the overall reform approach adopted by the health care sector is largely built around new, competitively oriented incentives. Among the core goals of these reform-oriented incentives is to ensure the delivery of medically appropriate and necessary care rather than unnecessary, excess services.

While many of the hospital payment reforms are designed to create incentives for efficiency, competition, and productivity, some patient risk is inherent in provider incentives. If the incentives are too strong and not otherwise subject to control, a danger exists that patients will fail to receive adequate care and treatment. Services to patients must be efficient, but not at the cost of premature discharge. In the United States, these concerns are often summed up in the expression “sicker and quicker”—which describes the rapid movement of a patient through the hospital component of the health care system.

Both to encourage the improvement of hospital-based medical practice and help control the potential perverse patient care incentives of the new payment system, work continues on developing a quality assurance (QA) system. The QA system in its entirety covers both ambulatory group practices and hospitals; at present, however, the hospital component is further advanced.

By late 1995, ZdravReform helped build a system to review and monitor facility use and quality in the MHI Fund health insurance program. By early 1996, the Issyk-kul oblast health department and MHI Fund had established and staffed a Quality Assurance Department. The department, in conjunction with hospital leaders and Abt, has developed admission and discharge criteria for conditions that account for half of all hospital admissions. In addition, a facilities' accreditation program designed by ZdravReform for the Kyrgyz MOH is undergoing pilot testing in Issyk-kul oblast while a national accreditation committee is forming.

Finally, although its implications are broader than for the hospital sector alone, the consolidation and integration of the payment of the Issyk-kul MHI Fund and the oblast health department budget in mid-1995 represented a major breakthrough. By mutual agreement, the consolidation eliminated potential discord associated with a two-payor (health department and MHI Fund) system; the ability to play off one provider against the other when looking for funding; and the duplicative overhead functions associated with the insurer and government health department. Since the merger, providers face a single payment stream that sets reimbursement on a DRG per case basis.

2. Kazakstan

Kazakstan has a substantial history of health care reform. As early as 1989, before the breakup of the Soviet Union, the nation identified five sites in which to conduct reform experiments and demonstrate alternative approaches. Kazakstan even undertook a comparative analysis of alternative health care financing systems as a prelude to adopting demonstration site approaches. Out of this

pre-ZdravReform experience, national, oblast, and local entities largely defined goals, considered options, and selected general approaches. Dzhezkasgan concluded that significant reductions were necessary in the oblast's overbedded hospital sector. Rationalization steps taken to date include the closure of substantial numbers of beds and the elimination of associated personnel.

As compared with its role in the Kyrgyz Republic, Abt's activities in Kazakhstan have been less directive than consultative. It has pointed out areas of potential difficulty while assisting local leaders in implementing a wide variety of reform actions. In part because of the experimentation that preceded Abt's involvement, ZdravReform's activities might be broadly characterized as ensuring that the interim steps completed at the subnational level help to further longer-term reform goals without imperiling advances to date. In this vein, ZdravReform has undertaken the following in an effort to sharpen hospital inpatient efficiency incentives:

- C It helped the Dzhezkasgan MHI Fund move from a per diem hospital payment system—itsself a dramatic 1995 reform of the former Soviet chapters budgeting structure—to a more sophisticated, clinically based per case reimbursement methodology (previously described) effective July 1996.
- C It assisted the Semipalatinsk MHI Fund and oblast health department in further refining their clinical case-based hospital payment system.

While the Issyk-kul MHI Fund and oblast health department in the Kyrgyz Republic merged to create a single-payor system with a single benefit package, Kazakhstan has followed a different national route. Even as the national and several oblast MHI Funds were being established, the Kazak Ministry of Health decreed establishment of two benefit packages, each with a different funding stream.¹

- C The Basic Benefits Package is the responsibility of the MHI Funds. Its key components are planned (i.e., nonemergency) hospitalizations and most outpatient care.
- C The Guaranteed Benefits Package is the responsibility of the Ministry of Health. Public health services, emergency care, most acute care and serious but nonlife-threatening cases, and all specialty clinics (e.g., TB, infectious diseases, and psychiatric facilities) fall under the direction and funding of the MOH.

Because of the benefits bifurcation, providers in general but hospitals in particular face substantial administrative problems. Each case requires a determination of provider accountability and financial responsibility. Worse, building incentive-based payment systems, which are essential to reform, becomes at best extraordinarily difficult and, practically speaking, virtually impossible.

¹The inadequate and unsatisfactory explanation given by the director of an oblast MHI Fund for the MOH action was, "Politics." Further exegesis was not forthcoming.

Recognizing the difficulties represented by the MOH benefit/payor dictum, ZdravReform sought to target its efforts to those oblasts willing to establish a single benefit package/payor system despite the MOH directive. For this reason, ZdravReform has focused its Kazak efforts on the Dzhezkasgan and Semipalatinsk oblasts. With regard to hospital payment, the approach at these sites largely parallels that in the Kyrgyz Republic.

3. Conclusions

From a technical perspective, the incentive-based hospital payment methodology developed by Abt and adopted by the Kyrgyz Republic's Issyk-kul oblast intensive demonstration site is more holistic, elegant, and complete than the similar but more fragmented approach adopted by the Abt-assisted Kazakstan demonstration sites. The variation reflects, in large part, the different levels of earlier experimentation in the two countries as well as the level of commitment to reform. While the level of experimental activities in Kazakstan may have exceeded that in the Kyrgyz Republic, the general level of commitment (political and otherwise) to broad reform in the health care sector was—and may continue to be—significantly higher in the Kyrgyz Republic.

The management information systems put in place to develop DRG payments support a wide variety of other functions at little additional cost. For the first time, hospital heads—both medical and administrative—have access to empirical, management-relevant information. Quite literally, the information systems' current and potential impact on costs, quality of care, and practice patterns cannot be overdramatized. They form the basis of and enhance the imperative for continued radical change toward outcomes-oriented, science-based, hospital-based medical practice.

On the other hand, much of the work to date and the expected benefits—incentives for and tools to achieve improved management control, enhanced efficiency, higher-quality care, reduced costs, and reduced duplication through provider rationalization—remain largely theoretical.

- C Neither country is experienced in making DRG-based hospital payments. Operational implementation is just beginning.
- C Given the available time, the amount of work required to address hospital payment reform has been immense. Work is still underway to develop outpatient payment system reforms.
- C To date, the financial resources necessary to fund the incentives inherent in the DRG payment system are largely absent. The problem is especially troublesome in the Kyrgyz Republic, where many health care workers at all levels have not been paid in six to nine months. The hope is that the World Bank loan will help remedy the problem.

In both countries, key hospital personnel interviewed several times by the evaluation team noted that the information collected to support payment analysis allowed them to achieve savings in their own facility operations. But the savings only helped keep the facility barely afloat absent anticipated resources. Resources for new investments, no matter how large their expected returns, were said simply not to be available.

Although operational experience is virtually nonexistent, it is clear that forces have been let loose which, like the genie, cannot again be easily put back into the old bottle. Even members of the “Old Guard” interviewed by the evaluation team acknowledge that they will not and cannot return to the old days.

- C One Kazak rayon central hospital head remarked on the magnitude of the cost differences among some of the hospitals for which he had oversight. He had not recognized these differences before introduction of the MHI Fund’s payment reform-related data collection effort and could not explain them to his own satisfaction through reference to severity of illness or other exogenous factors. His sense of professionalism led him to want to “fix” these unexplained disparities as efficiently as possible.
- C An MHI Fund director in Semipalatinsk noted that a set of hospital doctors had become engrossed in exploring the occasional gap between “standard practice” (prekazy) and “good practice.”
- C The head of the Issyk-kul MHI Fund spoke with enthusiasm of the briefing she would soon give to an audience of her peers from both Kazakhstan and the Kyrgyz Republic on the benefits of the DRG system. A believer herself, she hoped to convert doubters.

In Kazakhstan, it is not yet possible to know whether and how the dissonance between the demonstration sites’ single-benefit/single-payor structures and the Ministry of Health’s directive will sort out. During the evaluation team’s fieldwork, Abt scheduled a major presentation of the Semipalatinsk experience for November. Oblast representatives were hopeful and positive. On the other hand, during a meeting with the team, the Deputy Secretary of the Cabinet was less supportive, expressing the view that no hard evaluation of the demonstration sites had yet been undertaken and that such a study would be necessary before any decision was reached.

C. Primary Care Restructuring and Payment Reform—Findings

In both countries, perhaps the key single element of delivery system reform is reversing the disparities between hospitals and polyclinics and primary care providers. As previously noted, the disparities stem in part from and are the cause of the traditional low status and income, inadequate training, and limited competency of primary care providers. In the Soviet era, the incentives structure required primary care providers to act not as caregivers or gatekeepers but rather as entry points, passing on to polyclinics and hospitals the overwhelming majority of true medical cases.

Activities of ZdravReform and others to bring about a reversal in the role of primary care providers are spelled out in detail elsewhere in this report. Here, the focus is on the role of payment reforms in efforts to strengthen the role of primary care providers.

In both countries, the intensive demonstration sites have adopted reforms that establish ambulatory care family group practices (FGPs). The hope is to move rapidly toward “funds’ holding” following the model of Great Britain’s recent ambulatory payment reforms and U.S. health maintenance organizations (HMO). The goal is to create economic and other incentives critical to reducing medically unjustified referrals to polyclinic and hospital specialists, increasing productivity, and enhancing competency through additional training. And, of significance to democratization goals, the restructuring underway is now or will shortly start providing consumer freedom of choice among providers for the first time in both countries.

1. Kyrgyz Republic

Issyk-kul is the furthest advanced of all the demonstration sites visited. Physician participants have voluntarily formed more than 80 FGPs. Typically, each FGP consists of two or three physicians—an internist, an obstetrician/gynecologist, and a pediatrician together with nursing support. Each FGP is associated with a practice manager trained by ZdravReform to provide financial and management services to the practice. (A practice manager may serve more than one FGP.)

The FGPs are actively engaged in marketing themselves to potential enrollee families, each of which is free to select a practice on the basis of proximity, reputation, or other factors its members may deem important. Not only do enrollees enjoy free choice of the FGP with which they associate, but, remarkably, they will also be able to disenroll and change their affiliation on liberal terms. Overwhelmingly, the FGP enrollee target population has responded favorably to date, with more than 80 percent of the target population enrolled.

FGPs are to serve as fundholders paid a capitated rate per practice enrollee. When fully operating in the next year, FGPs will be responsible for the costs of all inpatient as well as outpatient care. As with U.S. health maintenance organizations, the FGP operates in response to economic incentives for providing care within the practice as efficiently as possible while avoiding unnecessary specialty referrals and hospitalization. Key safeguards against economically induced underservice come from a combination of quality assurance oversight (provided at least initially by the combined MHI Fund/Issyk-kul Department of Health) and the right of the enrollee to “walk.”

The major problem faced by primary care payment reform is financial. Restructuring to establish FGPs in Issyk-kul oblast was supposed to be accompanied by the availability of 1.2 million sommes to support incentive payments and bonuses. In an area where many physicians had not received salaries for more than half a year, several expressed doubt that the funds would be made available.

During the period of the evaluation team's visit, strong rumors suggested that resources were being made available to bring salary payments current and that the incentive account would be fully funded. At a meeting with the Ministry of Finance, however, it appeared that only 300,000 to 400,000 sommes had actually been apportioned. How the funds would be used—to help bring salaries current or to establish productivity incentives—was not fully clear. Nor was it possible to secure information as to whether the partial apportionment was only temporary, with additional resources to be provided shortly.

2. Kazakstan

Dzhezkasgan oblast has largely circumvented the Ministry of Health's dual benefit package/dual payment system. The oblast health department has assumed responsibility for public health activities and their funding, although the MHI Fund finances virtually all other ambulatory and inpatient services on a case-based payment system.

The restructuring of the primary care system has been substantial, as evidenced by the formation of a network of more than 60 FGPs and one HMO-like entity, the Territorial Medical Organization. In general, the FGPs have been created out of groups of physicians formerly employed by polyclinics.

Free consumer choice of providers is expected when voluntary enrollment begins in mid-1997. In late 1996, the Dzhezkasgan oblast health department applied to the Soros Foundation for a grant to prepare the FGPs for open enrollment. If awarded, the grant would fund a public education campaign together with FGP training, equipment, and development of practice managers—all largely modeled on the efforts now underway in Issyk-kul.

Movement to a capitated primary care system based on FGP enrollment panels is planned for introduction in 1997. At present, however, the MHI Fund pays primary care FGP providers on the basis of a fee schedule, with patient copayments required to reduce unnecessary utilization. Even though the current FGP payment system is viewed as only an interim step toward a system with substantially larger provider incentives, the importance of this move away from polyclinic chapter budgeting should not be minimized. In combination with the restructuring of primary care, the interim payment system will familiarize providers with the kinds of productivity incentives enhanced by capitation.

3. Semipalatinsk

In 1995 and with assistance from ZdravReform, the Semipalatinsk health department began to restructure primary care. "Micropolyclinics," established within polyclinics, serve as primary care

providers in urban areas, with an emphasis on family and preventive practice. In rural areas, the geographically distributed primary care delivery nodes, which had formerly been components of rural hospitals, were made autonomous entities, with their budgets no longer dependent on the decisions of the affiliated rural hospitals.

Four rural Semipalatinsk rayons have been designated as demonstration sites. Newly autonomous units (SVA-FAPs) at these sites are paid a rayon-specific capitation rate for the population panel within their catchment area. The capitation payments are to cover all primary care service needs of the catchment population. Physician incomes are to be linked to productivity, control of inappropriate hospital referrals, and quality of care—a dramatic break with salary levels traditionally tied only to training and length of service.

4. Conclusions

As with hospital reforms, an experience-based evaluation of primary care payment reforms is not yet possible in that most reforms are not yet in place. Nonetheless, the restructuring to date of primary care delivery and the accompanying payment system suggests dramatic change. Specifically, provider incentives for enhanced quality and productivity, introduction of patient choice, steps to eliminate the traditional “move them up” referral patterns, enhanced provider autonomy, and efforts to refocus resources away from hospitals to primary care all represent a virtual revolution not only in the two countries’ primary care systems, but also in their health care systems as a whole. They hold the promise for vast improvements in provider efficiency and productivity and patient care, treatment, and service. Collectively, the package of primary care reforms in the two nations will make the system more responsive to patients and substantially more “user friendly.”

Without exception, the reforms under consideration reflect credibly on all involved: providers, insurers, government policy makers, and ZdravReform consultants. The reforms are solidly grounded and offer considerable promise. Among the providers, urban and rural, with whom the evaluation team met in the Kyrgyz Republic and Kazakhstan, most who demonstrated knowledge of the proposals recognized the activities for their great potential.

Nonetheless, an issue of growing importance remains as demonstration sites prepare to move to the next stage in reforming primary care payment. That issue is the nature, definition, and extent of risk bearing and risk sharing between payors and providers. On the one hand, no mechanism holds such strong incentives to overcome the inefficiencies, traditionalism, and costly inappropriate referrals long endemic to Kazakhstan and the Kyrgyz Republic as does burdening the capitated primary care provider with financial risk for the full range of medical services his/her patients may need. On the other hand, virtually no other mechanism poses a similar threat to the financial rewards of careful, conscientious provider care and service than “the luck of the draw”—a membership panel unexpectedly composed of high-cost patients. It is true in a statistical sense that with a patient panel of sufficient size, the probability of a provider or provider group experiencing devastating financial risks is low. But the risk is neither nonexistent nor vanishingly small. Nor is it bearable.

At the time of the evaluation team's visit, no decisions had yet been reached on the extent of the risk sharing that providers might face or the nature of protection that might be offered (e.g., risk corridors, the MHI acting as a reinsurer, cross-practice pooling, withholds, or other stop-loss protections). As risk-sharing arrangements continue to be explored, the team urges careful consideration of the appropriate balance between payor and provider protections. News of a provider's financial devastation resulting from unlimited risk would quickly circulate and have grave consequences for the larger reform program.

D. Cross-Cutting Observations

With no important exception, the contractor has met and often substantially exceeded all annual plan, strategic objective, and substantive targets. Contractor personnel have earned considerable respect and receive high praise even from those who disagree with the policies they are helping to promote. In-country expatriates bring an unusually strong sense of dedication and commitment to making ZdravReform succeed.

ZdravReform is participating in a revolution in health care. But revolution, virtually by definition, begets contrary forces. Added primary care responsibility is achieved only at the cost of a reduced role for hospitals and a reduction in the resources available to secondary and tertiary care givers. The enhanced autonomy of the primary care sector threatens that of other sectors. If new mandatory insurance funds and old health departments cannot find a way to work together, ongoing tensions over roles, responsibilities, and resources will undermine many of the likely successes that reform promises. In a period of horrendous unemployment and underemployment, employers see their costs going up.

The ferment in the health care sector is taking place amid a perilous economic and societal context. The forces that necessitate reform concurrently pose the greatest threat to its success. Yet the prognosis is not gloomy.

- C First, if the projections for the success of reform have any validity, patients themselves may over time become reform's chief advocates. Economists, however, see little useful analytic distinction between mandatory health insurance now evolving in the Kyrgyz Republic and Kazakhstan and that component of general taxation that supported "free" health care under the former Soviet system. But emotionally, they are worlds apart. In informal discussions, the team repeatedly heard from consumers variations on the theme "I have insurance and I have choices I didn't have before," even in the currently early stage of reform implementation. If primary care family group practices can satisfy emerging patient demands relatively rapidly, the pressure to maintain and expand reform will grow.
- C Second, the evaluation team would argue that even if ZdravReform in all of its particulars were to fail—an unlikely outcome—it would nonetheless have proved a success in the most vital of ways. Country participants in ZdravReform—whether working for Abt, the various mandatory health insurance funds, or oblast and rayon health, financial, and other departments; physicians who hope not only for improved personal financial station and

enhanced professional autonomy but also for a more effective health care system; practice managers who are establishing a new profession day by day; and many others—have been exposed to and trained in and internalized new ways of thinking about and analyzing the possibilities, opportunities, and pitfalls of the marketplace and advertising. These are the tools that support democratization, competition, and hope and that will be carried to the broader world beyond health care.

- C Finally, a cautionary note is in order. The reforms already underway, soon to be implemented, and under consideration for the future are all-encompassing. Virtually nothing touching on health care is unimportant to the potential success of the reform package as an integrated whole. As a result, the demands that Abt in-country staff and their subcontractors make on themselves and the demands made on them by others are immense. These demands will expand as roll out of the demonstrations to additional sites begins. In this context, the evaluation team cautions that, with current staffing resources, the reform effort may have to select carefully from among the various issues it addresses. Certainly, it does not command the resources to address all issues in the detail they require.

III. SERVICE DELIVERY—KYRGYZ REPUBLIC

A. Health Status Context

With a total population of 4.5 million (1993), a large share (69 percent) of the Kyrgyz people reside in rural areas. Higher fertility rates in rural areas countered by substantial out-migration from the nation balance out the Kyrgyz Republic's population growth. In fact, the country has experienced declining life expectancy for various reasons. Specifically, the country is in the midst of the epidemiological transition from predominantly infectious diseases to chronic diseases, and yet both types of illness afflict its population, challenging the health care system to respond to and plan for both health conditions. In terms of health issues, cardiovascular disease (CVD) is the most common cause of death for both sexes, followed by accidents and intoxication, which rank first for 15 to 44 year olds. For females, respiratory disease and malignancies are major causes of morbidity and mortality. Among children and youth (0 to 14 years), 50 percent of all deaths result from acute respiratory infections.

The state's Program for a Healthy Nation, which was approved in 1994, assigned priority to five areas for improvement: family health, maternal and child health, protection of the environment, safe drinking water, and healthy lifestyles. Facing an infant mortality rate of almost 30 per 1,000 live births and a maternal mortality rate of 65 per 10,000 women of child-bearing age, the country defined its targets for the year 2000 as follows: reduce infant mortality by 25 percent, maternal mortality by 25 percent, CVD and cancer by 15 percent, TB by 10 percent, STDs by 50 percent, and diabetes mortality by 20 percent.

An evaluation of the health status of the country must take into account the delivery system in terms of the oversupply of facilities and generous staffing ratios. The Kyrgyz Republic has at last count one central (national) hospital, five regional hospitals, 50 specialized hospitals (including maternity and children's hospitals), 36 city hospitals, 40 district hospitals, 137 rural hospitals, 191 polyclinics, 930 feldsher/obstetrical stations, and 430 pharmacies. In terms of hospital beds, there are 12.1 beds per 1,000 people, contrasted with that of 9.3 in the OECD and 4.8 in middle-income countries. The average length of stay stands at 14.9 days with an occupancy rate of 79 percent. Besides being overbedded, the country suffers from a glut of physicians (15,000), with a ratio of 33.5 doctors per 10,000 population. This compares to 19 per 10,000 in the OECD and is even higher than Belgium, which has 26 doctors per 10,000 people.

B. Health Care Delivery

1. Family Group Practices

From 1986 through 1992, Gorbachev pursued the New Economic Mechanism (NEM) program, which contained among its many components a theoretical model of specialty care practice known as APTK. This was an administrative rather than functional designation that resulted in variable success as independent units. The APTK formed the backdrop for the development of family group practices (FGP), defining the needed element of change. This was mostly a physical change rather

than an organizational change, with the FGP relocating outside the polyclinic, but it laid the groundwork for future developments. Initially, the FGP was an extension of the polyclinic and reported to it, causing patients to view it as inferior to the polyclinic and with reduced access to equipment.

Much of this was to change, however, when ZdravReform began in early 1995. As early as the previous year, the government suggested Issyk-kul as an intensive demonstration site in recognition of the reforms that had already taken place there. With its mix of rural and urban populations, its middle socioeconomic status, its capable staff, and attempts at reform, Issyk-kul was attractive for experimentation. Moreover, interest in mandatory health insurance gave rise to legislation in 1993. Although such legislation had mandated but not implemented health insurance, the oblast was primed for change. Karakol city, with its population of 60,000, as well as three rayons were to be the locus of new ZdravReform activity with the local health authorities. With consolidation of the MHI and OHD in mid-1995 as well as new leadership in the form of an articulate and skillful female physician, Issyk-kul oblast took the next steps. The OHD realized that it was unlikely that the MHI fund would relieve the pressure on the government for the economic support of the health care delivery system. Nevertheless, all agreed that the central issue was more efficient use of funds and that the system needed to operate within existing financial conditions. ZdravReform expressed concern that the MOH did not fully understand the MHI and thought that ZdravReform was planning to implement a health insurance tax.

The original intent was to pool all resources and apply changes just to Karakol and the three rayons; however, in mid-summer 1996 the decision was made to develop FGPs throughout the oblast. Original projections of the need for 200 FGPs were too conservative. Reconsideration brought the estimate down to about 80 practices as a sufficient number to cover the oblast, with each FGP capable of serving as many as 6,000 people.

The formation of FGPs supports the initiative to move toward a market-based economy. To date, 81 FGPs have formed within the IDS of Issyk-kul oblast. Providers have joined together in groups of two or three, creating partnerships based on compatibility (personal and professional) and proximity to the catchment areas previously assigned in the Soviet era. Two associations, one urban and one rural, monitor and support the FGPs in two critical ways: oversight of the work of recently introduced practice managers and assistance with applications for grants for renovation of physical facilities and for equipment essential for carrying out clinical tasks at those facilities. A previous consultancy in 1995 (Buxbaum) identified the essential clinical equipment for the FGPs. So far, 40 percent of FGPs are fully operational with renovated facilities and the basic tools for practice. The FGP associations track and facilitate the progress of such renovation and outfitting. The FGPs are eager to engage fully in clinical practice for the local population that has chosen them as providers.

The role of the association in support of the FGPs has been critical, particularly as to official status and advocacy. The work has been accomplished largely through the efforts of two women physicians who were elected by the rural and urban groups and who have served ably in the association's first years. The urban and, later, rural FGP associations registered with the Ministry of Justice, applied for nongovernmental status and nonprofit tax exemption, and opened bank

accounts, thereby facilitating their operation as legal entities. When the FGPs encountered some problems at the outset in terms of location and equipment, the association assumed an advocacy role and applied to ZdravReform for grants. The first grant was awarded in 1995 for \$24,000, which was used for facility renovation and the purchase of basic equipment. Two grants allowed for the purchase of computers and equipment, which in some cases made the FGP better equipped than other polyclinics. A second round of grants of \$22,400 each to the urban and rural associations boosted efforts for completion of some facilities and allowed a quicker start of services within the community. Funding decisions consider that rural practices differ in the need for training of feldshers, the management of finances, the medical needs of a rural population, and the distance from authorities, necessitating more independent decision making. FGP associations face the challenges of managing their own funds and exerting a new degree of managerial and fiscal autonomy.

The work of the FGP association head managers is supplemented by three internal experts with the FGP associations. These experts decide what is appropriate for clinical management at the ambulatory level and what levels of care may need referrals. Thus, they function loosely as a utilization management team regarding both the prekazy as well as the economic incentives for the group's financial viability and growth. As their role dramatically expands, they have begun meeting more regularly to develop protocols on the basic aspects of appropriateness of care and equitable referral mechanisms.

2. Practice Managers

In March 1996, training began for the first generation of group practice managers. The training program consisted of the principles of health care, job requirements, health insurance, marketing activities, computer basics, and the organization of data collection and analysis. In addition, the course taught financial systems, the basics of statistics, and the development of inventories for the group practices and provided some English language training. The ratio of practice manager to FGPs is 1: 2 or 3, meaning that the practice manager divides his/her time between at least two different groups. When the initial call for candidates occurred, four to five applicants came forward for each position, testifying to the popularity of this new type of employment. Candidates were screened for basic knowledge of computers and English language skills. At the time of the evaluation, 30 practice managers were training to work in the FGPs.

The roles of the practice manager are evidence of the many tasks to be fulfilled in the day-to-day operations of the FGP. The practice manager prepares and manages statistical reports on the enrollment and utilization of services for the group. He/she develops monthly budgets and reports and contrasts actual versus budgeted amounts. Moreover, he/she analyzes the flow of funds from the kassa to the FGP. He/she is charged with the purchase of supplies and equipment and audits referrals and develops productivity profiles of physicians using a "Purvis" form (ICD-9 and CPT codes for common diagnoses and procedures, respectively). In all these activities, he/she collaborates with the head of the FGP association. To carry out these tasks, the practice managers use computers, some of which are based in Karakol. Others will be available for distribution to outlying areas so that the rurally based practice managers do not have to travel to Karakol for data entry and analysis.

Physicians were initially skeptical and then astounded at the capability level and achievement of the practice managers. The profiles of the practice and of the providers themselves is seen as a tremendous advantage to the competitive marketing of each FGP. The practice managers meet weekly to review the data entry, to discuss issues common to their FGPs, and to remain involved in marketing strategies. The potential for the data collection and analysis by the practice managers is readily seen as a step in the evolution of such measures as quality, access, utilization, and satisfaction. These ultimately will identify best practices, which can be replicated in FGPs that seek to gain the edge in the market.

3. Marketing of FGPs

To the credit of the ZdravReform marketing staff, an astounding 83 percent of the oblast has enrolled in FGPs. In the rural areas, 93 percent of the population of 40,000 in one of the rayons has enrolled in the newly created group practices. Given the high level of local population enrollment in FGPs at marketing campaigns conducted in 1996, the transition from service delivery through polyclinic specialists to delivery through an FGP would seem to be progressing rapidly. The evaluation team visited one of these campaigns in a mining village one hour's ride outside Karakol. Physicians participated in the sign-up by "marketing" their practices through written summaries extolling each provider's capabilities along with the potential benefits to enrollees who signed up with that particular practice; 17 FGPs represented themselves in this manner. Of the steady stream of villagers entering the enrollment office, the evaluation team briefly interviewed some enrollees and discovered a sophistication of understanding about how the enrollment data were used and why the new FGPs were advantageous to their health needs. A local provider not yet with an FGP expressed a keen desire to form an FGP and awaits training opportunities in Karakol. The training will enable her to compete for enrollees and to benefit from a practice manager in her practice.

Special acknowledgment of the marketing staff demonstrates two key activities for replication in other sites and countries: the level of organization, engagement, and energy involved in such high-enrollment successes; and the spin-off benefit for health education purposes. The marketing staff had laid the groundwork for wider publicity by first engaging community members in focus groups to learn about the issues most important to consumers of health care. They developed a logo for the FGP enrollment campaign, wrote up an information sheet and brochure in both Russian and Kyrgyz, and analyzed the community layout for better logistics of carrying out the enrollment activities. Taking advantage of an upcoming immunization event for the entire community, they designed a coloring book for children; made pins, plastic bags, and t-shirts with the advertisements of the FGP enrollment events; and wrote press releases for the local newspapers. In addition, they saw to it that local buses carried advertising displays. Not to be held back, they set up an information booth at the central bazaar in Karakol and pilot tested a concert and sporting events in Dheti-Oguz. The local television stations also carried the message about the enrollment opportunities within the FGPs. The marketing staff informed patients of the transition from the polyclinics to the FGPs. The staff explained the nature of consumer choice, the importance of a primary care structure, and the advantages of joining an FGP. These activities were a first for the Kyrgyz Republic. As a result, 72 percent of the population was enrolled in just four days between January 15 and 18, 1996.

Once this successful pilot was accomplished, the experience was applied more broadly. The marketing staff set up 51 focus groups to explore the population's knowledge of primary care and public choice as a means of testing the plan for further enrollment events elsewhere. A six-day enrollment campaign including a concert, health fair, and a karate and basketball competition followed. At eight enrollment sites, all representatives of the 16 FGPs were present, with 82 percent enrollment tallied at the end of the event. Of the 16 FGPs, six accounted for about 92 percent of the enrollment figures. This total was likely helped by the fact that doctors themselves assisted patients in filling out the enrollment forms, after presenting their credentials and the information sheets they had drawn up giving biographical information about the doctors in that particular group practice. Some doctors had also conducted door-to-door enrollment.

In conclusion, several elements made for successful enrollment campaigns. The activities were community-based and targeted to the local population in ways that were attractive. The outreach was strong and contained information that was of interest to the public yet retained the necessary educational content regarding health goals. In addition, the involvement of the doctors themselves lent credibility to the event. Finally, the strategic use of mass media drew in participants, with radio and television thought to be most effective. Exit interviews of the enrollees asked for information on the basis for the patient's choice of FGP and whether the choice was made independently. Although most enrollees chose their previous doctor, some patients switched because of the location of the FGP office. Patients also appreciated the health education material, particularly given the dearth of information and high literacy rates. For reasons not clear, the SES had declined to disseminate health education materials even though the local population was keen to learn about local health problems, particularly diphtheria, which had occurred in epidemic proportions. The marketing staff plans to conduct disenrollment tracking through patient satisfaction surveys later this year and periodically throughout next year. The staff will link the information with the registration forms, which show changes in choice of primary care provider.

4. Clinical Training

Clinical training is an early step in the successful formation of the FGPs. Providers, initially trained as specialists, must retool as generalists. The Scientific Technology and Language Institute (STLI) has joined forces with ZdravReform to undertake such training. In fall 1996, STLI's Center of Excellence in Karakol began outlining a strategy for training trainers, thereby enabling trainers to instruct providers in the core principles of family practice medicine. Competency examinations for a baseline fund of knowledge have been administered to about 200 providers, but the analysis of results is not yet completed. STLI staff have worked as consultants to Abt; in the future, STLI's work with Abt will be expanded through a subcontract with Abt and the World Bank. The impact of STLI's training has yet to be determined; however, initial evidence suggests that the training plays a key role in ensuring the present and future clinical viability of FGPs. Unless they become self-sustaining clinically, FGPs will devolve back to polyclinics; hence, the pivotal role of clinical training in family medicine is apparent.

Given that market-oriented reform is designed to "serve the customer," the clinical training aims to complement the scientific training with a service mentality aimed at patient satisfaction. Reports state

that providers have not always regarded patients' need for privacy or confidentiality and that deferential behavior toward the sick has not been the norm. STLI's Center of Excellence provides instruction in improving the patient-provider relationship through communication and courtesy. Improved interaction will likely be a patient satisfier beyond the clinical competency demonstrated at each encounter, thereby helping FGPs retain their patients.

5. Quality Assurance and Standards of Care

An upcoming challenge for FGPs relates to clinical standards known as *prekazy*. Developed in Soviet times, *prekazy* strictly delineate clinical diagnostic and therapeutic modalities as well as referral practices by generalists to specialists. The Sanitary and Epidemiological Service (SES) is responsible for developing the *prekazy* for infectious diseases. Anecdotally, the *prekazy* often dictate hospitalization and long lengths of stay for illnesses that may no longer require such approaches. Providers undergo strict review for compliance with such *prekazy* and may be fined or even barred from practice for failure to regard these dictates. Clinical training in family practice, the emphasis on more appropriate referrals, and the fiscal requirement for stricter utilization management introduced by ZdravReform pit *prekazy* against newer protocols and guidelines for generalist medicine. Indeed, *prekazy* may represent the greatest barrier for new family practitioners, as rigid "quality assurance" by *prekazy* have made practitioners generally reluctant to accept the new utilization management based on data from the financial information systems and tracking of resource utilization performed by practice managers. Accordingly, ZdravReform will play a central role in integrating data from the case-based payment system with data from appropriate service delivery at the facility level.

Nevertheless, alternatives to the *prekaz* system might present themselves. For example, in discussion with a new FGP in Dheti-Oguz, the evaluation team discovered that the FGP was applying UNICEF protocols for ARI, CDD, and pharyngitis. The FGP noted that although these protocols were not part of a *prekaz*, they were acceptable to the delivery system in part because they are linked to essential drug donations. The implication is that clinical guidelines linked to pharmaceuticals may serve as a two-pronged approach to changing clinical practice without overtly disrupting the time-honored but outdated *prekazy*.

The evaluation team met with three QA experts from the OHD, two members representing ob-gyn and surgery and the third as the assistant to the head of the OHD and director of the external expert team. Their activities have been centered on both retrospective and concurrent review of clinical cases throughout the oblast, which essentially means five central rayon hospitals and 117 facilities altogether. They are assisted in these endeavors by an internal expert at each hospital. The staff identified more problems than achievements but also expressed enthusiasm about the good beginning and solid organization underway. Moreover, they expressed a willingness to work to overcome some of the serious flaws in quality of care. They stated that monitoring quality of care was not a new undertaking and that the adherence to *prekazy* was the motivation behind many practices within the hospital and clinics.

Unfortunately, what was described was more aligned with a “bad apples” approach in which fines, retraining, and varying degrees of punishment ranging from restriction of practice to outright dismissal were the result of deviation from the *prekazy*. This is equivalent to the “cake versus the whip” approach (QA being the whip and QI being the cake.) The external experts said that the *prekazy* do not change and generally do not have to be reviewed, a statement that may reflect the immutable nature of these requirements for care and may indicate a significant barrier to the introduction of new practice parameters and clinical guidelines. As for continuing medical education (CME), which might stimulate a fresh approach to old clinical problems, the experts said that in the past such CME came from Moscow; funding was insufficient for such training nowadays, except that the assistant director had been on one study tour to the United States. The experts acknowledged that the state’s increasing attention to health care along with the organization of the MHI kassa will give momentum to changes in the monitoring of health services and utilization. They vowed not to drop the quality-of-care monitoring even if funding was lacking for their individual institutions.

The evaluation team also met with the Dheti-Oguz Rayon Hospital staff and toured the FGP located on the hospital premises. The discussion with the chief of internal medicine centered around the QA/QI activities at the facility and the collaboration with the external experts mentioned above. Daily rounds and monthly meetings focus on individual cases, referral sources and timeliness, consultations, clinical diagnoses, deaths and corresponding autopsy diagnoses, and correctness of “humanitarian aid.” The chief said that there had been no patient complaints other than the lack of pharmaceuticals in 50 percent of the cases. She said that feedback from referrals does occur, although getting the patient to the specialist’s office may require overcoming transportation logistics. She said that no patients had signed out of the hospital against medical advice and that no providers had been dismissed for quality-of-care infractions. She added that there had been no issues regarding nursing care, nursing oversight, or drug errors. It is not certain, actually, whether the chief actually monitors for these and whether the staff would report errors if noticed.

6. The Interface between Quality Assurance (QA)/Quality Improvement (QI) and the MIS

The role of quality assurance (QA) springboards from the MIS (management information system). QA activities in Issyk-kul oblast already have roots in the Soviet health service delivery system in that the *prekazy* required a review of clinical practices at the facility level. Not surprisingly, such review was not grounded in utilization resource requirements; rather, it served as a kind of policing function compatible with the control style of Soviet medicine. Nevertheless, ZdravReform’s two earlier consultancies in QA (Farmer, 1994; Pasternak, 1995) have laid the groundwork for change. These consultancies initiated thinking about QA/QI and began the development of admission and discharge criteria for ten common diagnoses. However, the effort has not progressed because the initiatives depended on the successful launching of other components of the IDS, namely, the MIS and the establishment of practice managers trained in enrollment data entry and data analysis for practice feedback to providers.

To date, the IDS has established a QA Committee headed by the former director of the city hospital in Karakol and staffed by a small group of “external experts” representing various key specialties. The committee is complemented by “internal experts” at some facilities who review all cases for

diagnosis, treatment, referrals, and mortality (autopsy rates and concordance of pathological findings with clinical diagnosis). An evaluation team interview of the chief of internal medicine at Dhetti-Oguz Rayon Hospital revealed that QA review does not extend to areas where traditional QA may range, such as nosocomial infection rates, drug dosing errors, adverse reactions to treatments (such as blood transfusions), or postoperative complications. The rayon hospital's method can be likened to the "bad apple" approach, whereby deviations from prekazy result in admonitions, fines, or even dismissal. No attempt is made to search for best practices and then replicate those within the facility. In addition, the QA approach does not report patient or provider concerns.

The foundation of the MIS and the establishment of practice managers offer the potential to change the existing QA practice to quality improvement (QI). Practice managers, hired in late summer 1996 and equipped with computers, have begun to enter into the MIS programs the enrollment data that provide the demographic database needed as a first step for descriptive epidemiology. Once individual patient encounter data are entered into the database (using ICD-9 and CPT codes), the information system has the capability of developing practice profiles for each FGP as well as for each clinical department within hospitals. These data are largely intended for accounting and "billing" purposes but can readily become the basis for quality indicators, monitors, and sentinels (e.g., as an early warning system for over- or underutilization of resources as in the case of referrals to specialists).

The real power of an MIS will come with the application of universal standards for good practice such as preventive health services (e.g., immunization coverage, prenatal care visits, mammography rates), utilization measures (e.g., Cesarean section rates, hospital admission and readmission rates), and access parameters (appointment availability, hours of service, after-hours care, and panel size of practice). Used in a manner similar to HEDIS (Health Plan Employer Data Information Set), such quality indicators can be used advantageously for several purposes: to seek best practices at the level of the FGP and hospital; to benchmark FGPs and hospitals against one another; to market the differentiation of FGPs at enrollment campaigns to individuals as well as to employer groups; to challenge facilities with performance parameters below standards to meet or exceed new standards; and to accredit facilities. The last may be one of the most powerful tools at the national level, should the Ministry of Health choose to accredit facilities; at the local level, accreditation can serve as a potential marketing tool.

7. Grants

To encourage reform at the grass-roots level, ZdravReform has made grants for small projects in training, facility renovation, equipment procurement, and individual provider health surveys. It funded 14 out of 72 applications for a total of almost \$209,000 in Central Asia. One recent example is the rural health care outreach conducted by the Zhaiyl Firm from September 1995 to March 1996 in Aksyiskii rayon (Kyrgyz Republic). A team of four members visited six remote villages to conduct a study of current health issues in the local population (878 adults and 336 children). The team collected data on a laptop computer funded by the grant. The team also distributed medical literature and provided health care services to the local population. Key findings of the survey identified anemia, nutritional deficiencies, and hypertension as the primary health problems; moreover, the team noted local training deficiencies, which allowed for the referral of providers for further training in Karakol and Bishkek.

8. Partnerships

A noteworthy aspect of ZdravReform's efforts has been the forging of partnerships to complement the contractor's activities. Within the area of clinical training, STLI has carried the weight of idea generation, implementation, and monitoring of medical competencies for family practice initiatives. Because the training and retooling of physicians has been an integral part of the transition from specialty care to family medicine, STLI has played an essential role in converting polyclinics to primary health care centers. In addition, it has acted as a "project-extender" by going beyond the purview and resident expertise of ZdravReform. STLI's plans to relocate its base of operations for curriculum development and medical training to the capital of Bishkek will allow the ZdravReform IDS principles to carry greater influence and thereby contribute to the sustainability of the concepts of family medicine.

Generously funded by USAID, the American International Health Alliance (AIHA) has the potential to contribute to ZdravReform activities within health care reform; at present, its work largely focuses on the institutional level, primarily hospitals. Yet, the critical pathways developed for hospital practices offer the potential for supporting the QA/QI initiatives that grow out of the MIS and FGPs of the IDS. The degree of sharing of QA/QI practices between hospitals within AIHA's influence will largely determine the extent to which ZdravReform's priorities for reform are echoed by AIHA activities. The Centers for Disease Control and Prevention and the BASICS project contribute epidemiologic and child survival activities, respectively, to the list of health projects in the Kyrgyz Republic. A major World Bank follow-on loan that builds on the MANAS Project orchestrated by the World Health Organization (WHO) in 1995 will provide continuity of effort on a nationwide basis. The World Bank work will develop local capacity through targeted and integrated activities in other oblasts, somewhat similar to the IDS in Issyk-kul oblast. British, German, and other donors may be adding to the work in medical training and outfitting of health facilities.

9. Models of Service Delivery and Clinical Care

Three settings were visited by the team, two of which are detailed here. The FGP (#3) located on the Dheti-Oguz Rayon Hospital grounds was staffed by four doctors and several nurses. The majority of their patients had cardiovascular disease, pulmonary illnesses (both acute and chronic), and some gastrointestinal disorders. The practice had about 50 children under one year of age and a nonspecified number of other older children. The practitioners perform pelvic examinations on the women of child-bearing age and have pelvic tables for these examinations. They also had a couple of stethoscopes, a blood pressure cuff, scales for weighing adults and babies, and some minor items such as tongue depressors. The examination room was equipped with a table, chairs, built-in shelves, and clean curtains draped around the windows, which allowed a generous amount of light. They kept the medical records for their patients in neatly stacked shelves, according to age. The walls of the waiting area were recently painted and displayed colorful health education posters, most of which had a combination of text and pictures declaring a simple message. The group also had printed material from a UNICEF workshop on diarrheal disease, acute respiratory infections (ARI), pharyngitis, and other common ambulatory maladies of children. The morale of the staff was high and both nurses and doctors easily engaged in conversation about their work. They spoke supportively of the ZdravReform staff and its leadership.

Providers remarked that one-half of each day is spent outside the FGP visiting patients in their homes. In fact, a prekaz requires that all children one year of age and under should be visited in the home on a daily basis between the months of June and November, prime diarrhea and ARI season. Visits may take 30 to 40 minutes each, with providers usually dividing the labor. Providers had no problem with this requirement and thought it allowed them a better understanding of the whole patient in his/her own environment.

In contrast, the pediatric/family practice of a solo woman practitioner in a mining town of 1,300 some two hours outside of Karakol was not as fully equipped and organized. The solo practitioner essentially serves as the town's doctor, although there is a feldsher, nurses, and one midwife in town. In the last eight months, the doctor has delivered 23 babies without any maternal or neonatal deaths in the village. She sees 15 to 30 patients each day and had about 300 medical charts in her standalone clinic. She stated that the main medical problems in her population were hypertension and malnutrition. She denied any tuberculosis or cancer in the community and did not speak of pulmonary disease in her patients, a surprising fact given the mining occupation of many of the village's inhabitants (the mine operates at only 25 percent capacity, however.) Her clinic was undergoing renovation and painting but had three examination rooms, a delivery room, a storage room, and a small "lab." It had electricity but no running water during the previous month. A few medicines, some oral rehydration packets, a sterilizer, a thermometer, blood pressure cuff, some possibly nonfunctioning or incomplete equipment (a centrifuge, an old stethoscope, and an otoscope), a small microscope (natural light source), and some sutures comprised her equipment. The doctor was helping with the local enrollment campaign, although she was not yet officially registered as an FGP. The town had an ambulance for referrals into Karakol.

C. Conclusions

1. Project Design and Project Target Areas

The activities and achievements of ZdravReform in the Kyrgyz Republic demonstrate progress toward market-oriented reform as broadly defined in the strategic objectives. The intensive demonstration sites in Issyk-kul oblast provide early indication that democratization, privatization, and social change are at work within the health care delivery system. Provider interest in the new vehicle of delivery—the family group practice—along with the competitive nature of enrollment campaigns and the increasing level of interest in the position of practice manager all speak to market forces at play within the pilot area. Moreover, attention to consumer access to the health care delivery system, coupled with choice of provider, efficiency, and quality of care, demonstrates that reform is taking root within the community. Although a brief visit cannot detect the nuances of impact, anecdotal observations would indicate that both consumers and providers within the system welcome changes and initial achievements.

Not only has ZdravReform proven itself successful at the IDS level in Issyk-kul oblast, but other components of the project—most notably clinical training for the fledgling FGPs—have also emerged and taken on an importance of their own as the program gains momentum. Although neither the contractor’s original mandate nor key area of expertise, the clinical training initiatives allow ZdravReform to pursue health care financing alternatives more aggressively. Given that health care services and financing schemes are closely linked, the success of one is closely tied to the other.

The contractor’s activities are directed at the priority needs identified under the project. These needs are understood by and consistent with Kyrgyz political priorities but may not be within the government’s capabilities to address without assistance. The need for considerable restructuring of the delivery system, as much in terms of provider activity as in terms of physical facilities, demands clear action steps, which ZdravReform and counterparts have defined. The economic picture presents the greatest constraint and could potentially influence the sustainability and replicability of the successes of the IDSs. Project targets for clinical training and support appear attainable in light of present economic realities but may be limited to the geographic areas where ZdravReform has been working if assistance is not continued.

Some synergies have been realized with the work in Kazakstan, largely in the area of information systems for the group practices. Project design issues affecting the progress of project objectives and targets have to a large extent been resolved; however, resolution of the issues required arduous negotiation of management styles, country action plans, and even equipment procurement policies and procedures.

2. Implementation and Delivery Modes

Economic and budgeting constraints within the MOH not only impede progress in some areas but also threaten achievements to date. Nevertheless, the IDS successes are an attractive piece of the reform solution that keep dialogue alive between the MOH, MOF, and the contractor. Moreover, the partnership between the contractor, Kyrgyz counterparts, and other donors has led to training

initiatives and information system components that are fundamental to further strengthening of the clinical delivery system.

Despite late project startup with respect to resident advisers for IDS activities, the ZdravReform organizational structure, management, and operational principles demonstrate the effectiveness of program implementation strategies. The contractor interfaces effectively with the counterparts at the oblast and rayon levels and, through the Almaty staff, with the USAID Mission. Counterparts are well integrated into project activities, particularly in marketing enrollment strategies, the leadership of the family group practice associations, and the training and deployment of practice managers. Counterparts' full engagement testifies to the local public's high level of interest in participating in the FGPs; in addition, Kyrgyz counterparts are capable of promoting replication, as demonstrated by both a round of successfully completed grants and local provider competition for another round of grants. New technology is appropriate to local conditions, but the economic conditions may hamper dissemination of information systems.

3. Achievements and Impact Potential

Several key changes as a result of ZdravReform would support the proposal calling for the IDSs to serve as an appropriate framework for health care reform. For example, the public and private vote in favor of the FGPs has given rise to consumer choice and satisfaction, provider satisfaction and incentives, provider differentiation, and a change in attitude, not to mention health promotion and disease prevention. The privatization of practices, framework for financial incentives, establishment of practice managers, and features of the management information systems (MIS)/financial information systems (FIS) show that the IDSs have developed a well-coordinated program with intrinsic drive for improvement. Moreover, the MIS/FIS offers potential for modifying utilization, driving QA/QI initiatives, benchmarking practices, and forming a stronger basis for marketing and competition. An openness to challenging the scientific basis for the practice of medicine is another indicator of successful intellectual intervention in resetting the modes of thought about modern medical practice.

Although the impact potential is high, the uncertainties of fiscal instability in the government temper hopes for broader roll out. The training initiatives—practice management and clinical training—and marketing approaches have achieved the greatest momentum; in fact, training can be sustained without direct USAID funding. A \$20 million sector loan from the World Bank will also contribute to sustainability.

4. Refinements and Modifications

The major lessons learned largely fall within the domain of project management and communication strategies between the contractor and USAID. A key refinement will be the contractor's willingness to delegate fully the clinical training component while ensuring that training objectives are synchronized with the other elements and pace of health care reform. Moreover, an enhanced mass media program focused on Issyk-kul's health care reform success is in order. Issyk-kul as an IDS

has developed the most complete marketing, clinical, management, and information system programs in Central Asia and is poised for implementation of the payment mechanism roll out.

IV. SERVICE DELIVERY—KAZAKSTAN (DZHEZKASGAN)

A. Health Status Context

As the second largest oblast in Kazakstan, Dzhezkasgan has a population of almost 500,000. The city of Dzhezkasgan is home to 136,000 of those citizens and has been the center of health care reform. Overall, the health status of the population is slightly better than that of the rest of the country, with an infant mortality rate (25 per 1,000 live births) slightly below that for the nation (28 per 1,000 live births) and a crude death rate of 8.8 per 1,000 (9.2 per 1,000 for Kazakstan as a whole). In 1995, the Demographic Health Survey (DHS) conducted the first national population survey. As for the working population, 30 percent are salaried while 70 percent gain income from informal sector employment.

B. Health Care Delivery

Over the past two years, Dzhezkasgan has focused on three key aspects of health care reform: rationalization of health care facilities (mostly hospitals); the concurrent reorganization of polyclinics into private family group practices, along with refresher training to assist in clinical skills conversion; and, most notable as an innovation, a single-payor system with case-based payments as well as payment from the MHI funds to private practices, thereby freeing the practices from dependence on direct payments by patients. By creating the financial conditions for growth, the neutral payment system, coupled with the reorganization of service delivery, has laid the groundwork for privatization of the health care sector. Ongoing technical assistance to the MHI Fund staff, along with small grants to private practices, adds to the pace of change.

1. Foundations for Family Group Practice Formation

Several changes that have occurred over the last two years testify to the vision and momentum of the oblast health administration and the smooth collaboration with ZdravReform. Although the 1995 signing of the mandatory health insurance law renewed discussion about payment systems, passage of the law was predated by the merger in Dzhezkasgan of basic health insurance and the guaranteed package of services. As a result, a single-payor system simplified financial tracking and payment methods. December 1995 saw the formation of FGPs, which received official approval from the oblast in May 1996. Of the 67 FGPs in the oblast, 19 are located in Dzhezkasgan itself, along with a private clinic (Tillman) whose success has set the pace and standards for the others. The clinic, along with two others—a private neonatal center and a private cardiology center—has received MHI funding. In rural areas, which account for much of the vast oblast, some FGPs are registered as independent entities; as freestanding units, they sign contracts with the MHI Fund. MHI funding is essential for the survival of rural FGPs. A city medical association formed to help with rural health care support issues.

Other activities have complemented the establishment of family practice groups. The oblast developed new positions in marketing, financing, auditing, and pharmaceuticals. State pharmacies were privatized at auction with the result that many small pharmacies opened. The oblast defined

an essential drug formulary, and a department within the MOH was designated to deal with drug procurement issues. Seminars were given on health care reform concepts. Providers and some administrators, initially unhappy with the withholdings for the MHI Fund, were enlightened by the head of the oblast health department as to the rationale for such actions. Through all these actions, Dzhezkasgan has placed itself on the map, with each step supported by the ZdravReform staff.

2. Payment System Impact on the Delivery System

Budgetary issues lie at the heart of any changes to the delivery system. The old budget system was based on chapters and the number of beds within the hospitals. In contrast, the new budget system is based on capitation and the MHI Fund, thereby providing providers with an incentive to reduce the number of beds. The MHI Fund, operational in June 1995, initially used a per diem rate. In April 1996, however, it calculated rates for each hospital and each clinical department. Initially, with hospitals not receiving their full expected budget, each hospital required a stable base rate of 50 percent for hospital planning. Anecdotally (no hard data), it would seem that the oblast started to adjust by decreasing the length of stay, with a resulting increase of 25 percent in bed turnover. A committee examined the rationalization of hospital utilization and made use of hospital billing forms for deeper analysis. Consequently, the oblast health department has managed to close or cluster some services (e.g., oncology, dispensary, and the ICU). In fall 1996, however, the oblast health department still perceived the case-based system as a “fantasy.” Fortunately, though, MIS capabilities allow some analyses of ICD-9 codes, age, gender, and costs by department and therefore may ultimately be able to link costs and utilization through anticipated quarterly reports. Fundholding remains a conceptual rather than actual activity. Because referrals outside the district are discouraged, providers attempt to retain patients for care and to manage such cases themselves. User fees (copayments) also decrease unnecessary self-referrals by patients to specialists; in contrast, the FGPs do not require copayments for care provided at their facility.

With rationalization and restructuring, a certain degree of competition occurs within some level of service delivery, especially between FGPs, consultative diagnostic centers, and hospitals themselves. The traditional 75/25 percent split in financing between hospitals and polyclinics changed in June 1996 when capitation was introduced. Plans for mid-year 1997 will further shift the allocation, whereby 50 percent of payments will go to inpatient services and the other half to ambulatory care. The shift will be accompanied by a 30 percent increase in capitation to the FGPs. Oblast officials are meeting these changes with both anticipation and a willingness to experiment with alternative payment mechanisms until a balance is struck. Moreover, the experiment is resulting in competition for catchment populations and a desire to expand services delivered within primary care settings, thus leading to fewer unnecessary inpatient procedures and shorter lengths of stay.

3. Quality Assurance

Increased efficiency accompanied by shorter average length of stay and lower costs has necessitated some review of appropriateness of care. Oblast health officials noted that increased efficiency and its accompanying effect have occurred both concurrently and through retrospective review. Hospital committees that review medical charts have been known to levy fines on providers for inadequate

care. A nurses' association formed to define (and defend) nurses' level of responsibility of care and to work for several common diagnoses. Doctors also formed a group to protect their rights in light of QA reviews and potential fines. They developed their own clinical protocols and have updated some prekazы (or held onto some old ones). Oblast health officials said that they also refined the medical economic standards for Tomsk and Kemerovo by adopting the most rational guidelines for their own hospital protocols.

Where there may be difficult QA issues, the QA Committee from the MHI Fund may be supplemented by the oblast health department staff. The committee selects those cases whose specific length of stay exceeds the average length of stay and reviews them in greater detail. In summary, three levels of oversight for QA are at work to ensure that equity and appropriateness of care are not sacrificed in the process of cost reduction: at the level of the FGPs, which have their own QA for hospital care of their own patients; at the level of the hospital itself; and at the level of the oblast health department to provide greater oversight and allow for trends assessment and rationalization of facilities based on observations of volume and type of cases.

One critical factor in moving QA/QI and utilization management issues forward has been the exploration of evidence-based medicine. A conference in May 1996 in Almaty encouraged literature reviews, research, and analysis of such common therapies as hyperbaric oxygen and laser therapy. The result is that the MHI Fund is considering whether to establish a department that uses evidence-based medicine to determine which services it will cover.

4. Evidence of Market Reform within Family Group Practices

The establishment of FGPs has had the desired result in terms of privatization, though not without professional reorientation and some personal sacrifice. The sense of autonomy of practice has invited initiative within the practice setting. The opportunity for growth of practice has led to more competitive thinking about the expansion of catchment areas. Moreover, the financial incentives for growth of practice and influence within the community have encouraged practitioners to rethink the utilization of specialists, particularly for referrals. Most FGP doctors admit to working longer hours and seeing more patients, but they also express a higher level of job satisfaction and a desire to increase their knowledge base to accommodate their family-oriented practices. They regularly make home visits, which usually account for 50 percent of their day, and some even keep evening office hours as well. Others work in the hospital at night to oversee care of the patients in their practice and possibly to maintain liaisons with another part of the medical community that has not bought into the primacy of ambulatory care. In addition, the power of word-of-mouth advertising is apparent to providers who are willing to go the extra mile to retain patients within their practice.

The competitive nature of family practice has signaled the need for coordinating services with a practice's nursing staff. Realizing the value of team coordination, some practices compete to employ the better nurses in an area. In searching for nurses for their practice, the physicians look for both competency and experience as well as for nurses' compatibility as team members, acknowledging that patients will judge the practice by its access and friendliness as much as by its technical capabilities. Some FGPs employ as many as five nurses in one office.

Patient satisfaction and “customer orientation” are on the minds of Dzhezkasgan providers. Providers recognize that the easy access, ready availability, “one-stop shopping,” and continuity of care that characterize family practice make the FGPs more competitive with the polyclinics and specialists. Nevertheless, there is room for improvement. Many practices lament their lack of basic equipment. Some have to share stethoscopes and blood pressure cuffs. Better-equipped FGPs would like otoscopes and ophthalmoscopes and even EKG machines, simple radiology equipment, and a laboratory. It would seem that some larger equipment requests would lead to redundancy within a larger catchment area; yet, the ability to perform hematocrits, urinalyses, blood sugars, and EKGs within the office would eliminate unnecessary referrals as well as indicate when a delay in referral would be detrimental to the patient’s health and possibly erode the patient’s level of confidence in a particular provider. Vaccinations are another service that several FGPs would like to offer, especially given the occasional lack of local organization for preventive services and the shortage of vaccines. To make their point, a number of FGP doctors noted the relationship between the Tillman Private Clinic’s many diagnostic and therapeutic services and its large patient following.

Besides discussion about a proposal to the Soros Foundation for equipment for FGPs, an opportunity presents itself for an independent enterprise to offer laboratory services and courier services (specimens and results) to groups of FGPs if adverse communication and transportation conditions could be ameliorated. A small grant from ZdravReform could jump-start the effort.

5. Clinical Training

The conversion of practitioners from specialists to generalists (family-oriented providers) is accelerated by clinical retooling through intensive course work. In 1995, the MOH charged the Almaty Medical Institute and Kazak Postgraduate Institute for Physicians with changing the curriculum for students and physicians to emphasize family care. Moreover, the MOH decreed that each oblast and major city in the republic must develop a network of family practices. The recently implemented training consists of four months of didactic sessions taught by specialty chairs in the field. The strategy has been to create a cadre of trained family practitioners first in Dzhezkasgan to be followed with the training of selected trainers.

The strategy is to repeat this model in other cities. Two-year plans call for similar courses in Balkhash, Ust-Kamenogorsk, Zhambul, Semipalatinsk, and a few other sites. The training director acknowledges that family practice training should be conducted not by specialists but rather by professional family practice physicians skilled in teaching methodology. As a consequence, the director is making an effort to create liaisons with foreign medical societies that might be interested in exchange programs and short-term training of Kazak physicians. To date, 30 physicians in Almaty, 67 in Dzhezkasgan, 47 in Balkhash, and 45 in East Kazakstan have received training. Some practices have been equipped, although it is not clear to what extent they are set up to apply their new skills. The next steps include pilot testing of the MHI Fund payment system in selected family practices and some competency-based testing for future board certification, which would grant family practitioners official status within the country.

If the FGPs are to grow and remain competitive, they will need to develop business plans and think strategically about the next five years. Business planning may, however, be premature for some FGPs that have not even considered the economic viability of their practices during the early phases of startup and implementation. Further and more immediately, FGPs need to consider hiring practice managers to administer the business aspect of their practices. Over the long run, the stronger practices better poised for risk taking and less constrained by traditional thinking will survive. They will take the lead and “buy out” the weaker ones. ZdravReform is in a good position to work with the oblast health department to identify those FGPs that wish to step into a future characterized by health care reform.

6. Models of Service Delivery

The evaluation team made several site visits. Some observations from these visits might shed light on the range of experimentation, privatization, and success of medical practice within the city of Dzhezkasgan.

The Victor Tillman Private Clinic. The clinic was started in June 1995, and many oblast health providers spoke of it with pride and envy. Supported initially in part by a small grant from ZdravReform and funds from the MHI, the clinic has taken on a momentum of its own while developing its own funding base and continually expanding its service area. Its success is largely attributable to the vision and dedication of its husband-and-wife team and to the many mainstream and nontraditional services offered to its panel of 7,000 patients. It counts both incentive payment and nonpaying populations and sees upward of 55 to 70 patients every day. If the number of physical therapy (electrophoresis) patients is included, then the number of patients rises to 200 per day. The clinic offers vaccinations and injections, simple laboratory services, electrophoresis, “dream therapy” for stress reduction, a limited number of pharmaceuticals, some daycare (observational stay), and selected psychiatric counseling (stress and substance abuse; the latter mostly addresses alcohol). It does not provide family planning (e.g., IUDs), pelvic exams, suturing, bacteriologic analyses, or laboratory services other than bilirubin and blood glucose. Staffed by three doctors, four nurses, and a practice manager, it is open seven days a week on the premises of the Tillmans, affording the practice both access and security.

Maternity Center and the Zhourek Private Cardiology Center. In contrast to the general practice at Tillman, the Maternity Center and the Zhourek Private Cardiology Center specialize in care for expectant mothers and babies and first-time cardiac patients, respectively. Both centers have received small grants from ZdravReform to develop their expertise. The Maternity Center boasts a 10 percent Cesarean section rate (U.S. rates range from 16 to 30 percent), 1,800 deliveries annually (7 percent of which are premature by weight criteria), and the survival of its smallest premature baby of only 840 grams (1 lb., 13 oz.), astonishing accomplishments given the setting within isolated Dzhezkasgan. Since 1994, the Maternity Center has offered rooming-in and paternal visits, parental privileges not known in the Soviet era. In another part of town, the Zhourek Cardiology Center prides itself on the care of patients with cardiovascular disease. Most notable is its establishment of a Cardiac Club for first-time myocardial infarct (MI) patients and a package of outpatient services that monitors and counsels patients for secondary preventive health purposes. Besides training nurses

and technicians in its services, the center has a defibrillator, oxygen delivery systems, and basic post-MI care capability within an ICU. The center hopes the ICU will decrease mortality by 26 percent within the first 24 hours post-MI. The center also targets high-risk patients in the community, such as diabetics and those who are overweight. In addition, it offers some secondary school education programs for students in hopes of primary prevention. It claims to have had no fines levied on it by the QA Committee.

Private and Public Hospitals. In contrast to these facilities, the Copper Plant Hospital and Oblast City Hospital provide inpatient care for Dzhezkasgan. The former is a 300-bed facility built for the needs of the 30,000 employees of the Samsung Copper Plant. With plans for over 800 staff and 125 doctors, eight operating rooms, and a ten-bed ICU, the hospital cost \$180 million. Its planners, however, failed to account for the impact of rapidly dropping copper prices. As a result, the facility now stands as a beautiful, lighted, and fully heated hospital empty of beds and equipment. It has the outward appearance of abundance, but from within it is a mere shell facing an uncertain future in a land desperate for funding and medical equipment. Not far away stands the Oblast City Hospital, a 1,000-bed facility that is poorly lighted and in need of physical repair. On one floor, the radiology unit boasts 300 CT scans a month. It is equipped with ultrasound equipment with carotid artery imaging capabilities and staffed by several well-trained technicians. In the surgical oncology unit, 26 of 32 beds are occupied by cancer patients. Occupancy is limited by the availability of the latest chemotherapeutic protocols in the face of high rates of stomach, lung, and breast cancers. The environmental and occupational hazards and exposures of central Kazakhstan raise questions about why this service has not evolved more fully. Both facilities demonstrate the mismatched funding priorities as a root cause for the oblast's unmet health needs.

Family Practice #8. Although one site visit to an FGP is not representative, FGP #8 in Dzhezkasgan is an example of a fledgling practice determined to succeed. Staffed by two pediatricians, one internist, four nurses, and one auxiliary, it serves about 6,700 patients. It is located some distance from the center of town and is housed in an apartment purchased by the city health department. The pediatrician interviewed by the evaluation team sees about 25 to 30 patients in the morning (busy practice) and makes about ten home visits each afternoon. She sees the advantages of family practice as closer contact with patients, more concern for and control over patient care (versus early referrals to specialists), and more satisfied patients who are willing to come to the office more often when health issues arise. The pediatrician, who lives in the catchment area and has worked in it for the last three years, senses that the group practice setting has benefited her and her patients more than any previous arrangement. The FGP meets weekly to discuss cases and to exert some measure of quality assurance of care. The group plans to hire a practice manager for about \$50 per month.

FGP #8 still faces some challenges and gaps. For example, 60 percent of the practice's income goes to utilities. As a result, the practice must rely on the MOH for assistance with heat, light, and water. The most frequent types of medical problems include malnutrition in children (no deaths, however) and hypertension and anemia in adults. The pediatrician does not administer vaccines but, along with the local health authorities, helps track those who administer vaccinations to children and who would otherwise fine her if the children in her practice were underimmunized. The medical records consist

of small notebooks organized on shelves, but they lack problem lists, drug lists, and allergies and contain no growth charts with percentiles for children, a surprising gap since malnutrition was stated as a common ailment of children in the pediatrician's panel. A small quantity of patient health education material was on the walls in the form of posters, but there were no brochures for patients to take home.

The office included a small second room used for such treatments as injections and simple wound dressing changes. A small glass-enclosed case in the room contained a few infant formulas and boxed cereals mostly for display rather than distribution. The apartment itself was small for the four practitioners. They share it on a rotational basis. The floor seemed thin and poorly supported; the waiting area for patients was small, cramped, and offered a small bench for those who wanted to sit. Only a few medicines other than those donated by humanitarian agencies were in stock. Even though the FGP can dispense some "emergency" medicines, veterans still had to buy their own medicine in outside private pharmacies. Despite the circumstances, FGP #8 seemed committed to continuing its practice and hoped for better funding in the future to support its efforts.

7. MIS

Besides taking the lead financially through the single-payor system and the implementation of the MHI, the oblast health department has enjoyed some early success with its MIS. With its expertise in both hardware and software and with support and training from the Almaty ZdravReform staff, the Dzhezkasgan staff appears to be primed for the next steps of application, such as QA/QI in the health care delivery network. At this point, the MIS can list the top 100 diseases, average length of stay, standard deviation for each length of stay, bed days, and number of cases by ICD-9 codes. Drill-down on any specific ICD-9 code allows disease-specific data at the level of the individual health facility and clinical department, along with patient volume and total payments. In addition, the data can be graphically displayed. The power of the data allows administrators to make intra- and interfacility comparisons that serve as the basis for rationalization and incentivization strategies. Next steps call for linking these measures to QA/QI initiatives such that utilization management is not only cost-driven but is pushed forward by disease management programs, outcome measures, and, potentially, provider profiling for incentives and replication of best practices throughout the provider network. The linkage of services, cost, and quality will be the strongest influencer of provider behavior and administrator decision making within the health care delivery system. This is clearly an advantage over the more traditionally oriented SES (Sanitary and Epidemiological Service), whose relatively limited scope of surveillance, underreporting, uncertain denominators, providers' diagnostic biases, and hospital selection biases never gave the true picture of events in the delivery system. Moreover, the MIS role in QA/QI will play yet another important role in restructuring, licensing, and accrediting health facilities.

C. Conclusions

1. Project Design and Project Targets

ZdravReform's collaboration with the oblast health department in Dzhezkasgan has resulted in several key changes that support the hypothesis that health care reform and market-oriented principles have taken root and are growing within and beyond the IDS. Clearly, activities within the IDS support ENI strategic objectives. Market-oriented principles are already at work within startup FGPs, as demonstrated by provider awareness of local competition for expanding panel size; the potential for greater revenue through greater access, longer office hours, and more comprehensive services to patients; the value added by a compatible and competent nursing staff; and the acknowledgment of the drivers of patient satisfaction that ultimately mean patient retention within the group practice.

By targeting priority needs within the oblast, the IDS has developed and implemented a strategy for clinical training that envisions an expansion of FGPs equipped to provide comprehensive clinical services that compete successfully with the traditional vehicle of care. If such targeting continues, sustainability and replicability are more likely. Moreover, with support from small grants, privatization and differentiation have taken a lead in service delivery. The result is pride in service, customer satisfaction, and some best practices. Dzhezkasgan provides three examples of private practices as evidence that small grants are appropriate for achieving project goals.

2. Implementation and Delivery Modes

At this juncture, there do not appear to be major issues that would impede further implementation of project objectives or attainment of targets. The overall achievements are testimony to the effectiveness of the contractor's structure, management, and operations collaboration and to the successful partnership between local counterparts and the USAID field Mission. More important, the initiative and willingness of oblast leaders to take some thoughtful risks has made the partnership particularly powerful and exemplary for other oblasts within Kazakhstan. The counterparts' achievements demonstrate their engagement in and commitment to the concepts behind health care reform in the face of initial local opposition. They have gained a momentum of their own for the implementation of the recommended changes. ZdravReform's staff advocacy in Almaty will reinforce that momentum.

New technology, largely in the form of information systems support, is appropriate for local capacities and needs. The ready acceptance of computer-based data management is demonstrated by the impressive output of numeric and graphic data generated by the local information systems (IS) staff. The next steps call for applying these competencies to QA/QI initiatives to refine further the delivery system and appropriate use of resources as service demand grows.

As for critical factors that lie outside the project's control and influence, it is not yet known how the larger population will perceive and accept the changes brought about by the new system of health care delivery. Unlike the market research conducted in the Kyrgyz Republic and Ukraine, the testing of public opinion has yet to occur. Profound indications for improved health care and financing schemes may propel reluctant consumers to accept the changes on a trial basis; initial satisfaction may convince them not to disenroll.

Work plans and task orders have been developed to keep the objectives clear and appropriately prioritized.

3. Achievements and Impact Potential

The advances in Dzhezkasgan indicate that the target can be met by the end of the contract. Given adequate preparation and staff support for roll out in new areas, several of the innovations have the potential for replication. Noteworthy achievements include the following:

- C A single-payor system exists as a result of the merger of basic health insurance and the guaranteed packages of services. The result is simplified payment and tracking of expenses and revenues.
- C A case-based payment system is conceptually in place with buy-in from both the oblast health administration and the network of health care providers.
- C Dzhezkasgan has become the first oblast in Kazakstan to finance health care facilities through the MHI Fund. MHI Fund payments to FGPs encourage a neutral payment system that frees the fledgling practices from dependence on direct payments from patients.
- C The oblast health department has quickly restructured the health care delivery system through the dissolution of polyclinics and the establishment of family group practices. Largely due to the vision and focus of the oblast health department and ZdravReform's guidance, the pace of change has exceeded that in other parts of the republic.
- C Rationalization of health care facilities is evidenced by the closing of some facilities, the earlier reduction of hospital beds by 13 percent and staff by 16 percent, and the decrease in length of stay with an attendant increase in bed turnover.

Even though the results are likely to be self-sustaining because of local will and vision, further efforts in other rayons will need continued USAID support, although less than at project startup. These efforts will promote market-oriented principles and ENI strategic objectives for systemic reform.

4. Refinements and Modifications

One powerful application of the current developments is to link MIS-generated data to quality improvement initiatives and the cost of interventions. The MIS has evolved to a degree that can generate data specific to facility, clinical department, and disease (ICD-9) with regard to such utilization measures as patient volume, bed days, average length of stay, and costs. These advances form the necessary foundation for QA/QI initiatives by incorporating outcome measures, disease management, and provider profiling.

Partly because alternatives have not yet been introduced, the existing and rudimentary QA system leans toward policing functions. The system presently encompasses committee peer review, refinement of medical economic standards (MES), and three levels of oversight, along with a provider (nurse and physician) role in setting standards and maintaining the domain of quality of care within the clinical rather than administrative decision-making arena. Taking the next steps in QA/QI will build on this foundation in response to a demonstrated interest in quality of care.

V. DESIGN AND MANAGEMENT ISSUES

While considering the technical issues discussed in this annex, the evaluation team also had the unique opportunity to look at program design and management. The team was not able to interview all the major participants in the design and early implementation of the program, but sufficient institutional memory remained in Washington and the field to inform the team of the environment in which the project was designed and initiated in Central Asia. The team was able to weave management and design questions into all the interviews, meetings, and question-and-answer sessions that followed formal briefings.

The core findings are that

- C the Central Asia ZdravReform project is well coordinated and managed by both the USAID Mission and Abt;
- C it is meeting or exceeding the targets outlined in the annual work plans;
- C the project is making a major contribution to the achievement of Central Asia's and ENI's strategic objectives; and
- C as it has evolved, the project's core design and implementation is efficient and effective in delivering high-quality technical assistance focused on health care reform.

The team spent considerable time analyzing the different roles played by the central project support offices (Abt/Bethesda and USAID/Washington) and the Central Asia support and implementation offices (Abt/Almaty and USAID/Almaty). That analysis generated several conclusions.

The original design that developed out of the proposal and contract process envisioned country site-specific health care reform interventions that would test and develop new ways of financing health care in the NIS. Because the contract activity was spread out over several countries, it provided for a strong management role for the two central offices (Abt/Bethesda and USAID/Washington). The management approach was consistent with conditions on the ground in the original target countries: new and often understaffed USAID Missions in the field. Further, as an agency, USAID had only relatively recent experience in working with transition economies.

Considerable political pressure pushed for a rapid startup of health care reform in the NIS; however, the model for introducing reform was flexible. The contractor would field teams to analyze on-the-ground conditions and then propose site-specific programs to test various models of reform and financing. Successful interventions could then be replicated on a broad and sustainable basis. In effect, the design was not locked in at project inception but rather would develop and evolve as the project matured.

Because of the project's centralized management and highly flexible operational design, the contractor was able to move quickly to initiate project activities. Despite political pressure to move

even more rapidly, the project started with remarkable speed. It would be hard to find a donor capable of mounting a major technical assistance effort with such rapidity as the ZdravReform program.

Changes that evolved from the program's rolling design would become part of new model interventions. The rolling design provided the project with a rapid-response mechanism to test new ideas and stay abreast of the rapidly changing reform environment in the countries of Central Asia. The process can be briefly described as follows:

- C The field staff, based on its considerable experience in testing reform models, enjoys the necessary latitude to change the demonstration model or add or delete available resources to test a new idea.
- C Annual country work plans reflect strategic directions for implementation. Component activities of the country work plans are described in task orders, which specify staffing, timetables, and budgets.
- C The Abt team in Almaty negotiates with the USAID Mission in Almaty and reaches an agreement.
- C The relevant document is then sent to the Abt/Bethesda office for budgetary review. Abt/Bethesda submits the task order to USAID/Washington for technical review and approval. When USAID raises technical or budgetary questions, Abt headquarters staff transmits them to Abt field offices.

Now that the project has matured, it is important to assess the overlapping authority between the field and Washington. Specifically, the timetable for the U.S. government's overall economic assistance program for Central Asia is 2002. The current contract provides even less time for testing and piloting new ideas in health care financing and delivery. All efforts should be made to streamline communication to move project implementation along as quickly as possible, with more project implementation decisions made in the field. Indeed, with USAID's current emphasis on reengineering and its substantial progress in linking field operations electronically, it should be relatively easy to develop a virtual team management system that meets Washington's requirements for information but allows for both COTR and contracting officer responsibilities to be devolved to the field.

In looking for ways to move the locus of operational responsibility closer to the field mission, care should be taken not to weaken the flexibility aspects of the project design. It is the rolling design that has made the project successful, relevant, and responsive. It should be maintained at all cost. The project's ultimate impact on the reform of the health care financing and delivery systems in Central Asia depends on this flexibility.

An important element of the project has been the validity of its operational methodology. The rolling design has performed well. Because of the site-specific analysis of problems and the locally tailored

design of project interventions, the demonstration sites have been able to target the most relevant issues for reform. The USAID and Abt field staffs have developed a strong sense of program vision, and their respective Washington support offices have bought into that vision. Project implementors believe firmly that the project is identifying many of the solutions to the problems of the health care system. The team also noted a similar sense of breakthrough among many of the Kazak and Kyrgyz officials who are addressing a range of health care problems.

The process of searching for and developing solutions to problems makes replicability and sustainability a more manageable task. The work in Karakol, Kyrgyz Republic, is a good example of how the rolling design allowed the Kyrgyz Republic and the contract field staff to focus on the most important problems and come up with a working design that offers potential for roll out to a national program.

The Mission in Almaty and the Abt contract team have developed a strong, mutually supportive relationship. Despite some initial startup problems in the relationship, they developed a vision that has guided the project. Startup problems in the relationship have disappeared with early successes. In allowing the contract team to take the lead in developing and implementing the project, the Mission has been supportive but not directive. In many ways, this is an exceptional example of a Mission adopting the reengineering guidelines and making them work in an on-the-ground setting. The contract team has performed well within a supportive environment, with the results of its analysis and program emphasis clearly seen in the Mission's strategic framework. The Mission has treated the contract team as professional equals and has differentiated roles so that the sense of a single team has emerged.

Nonetheless, the project is at an important stage in its life. As results are generated from the intensive demonstration sites, issues associated with replication and sustainability must be addressed. In this setting, it is important that the Mission and the Abt team reexamine their working relationship.

Abt has worked well with counterparts at the national, oblast, and suboblast levels. Except in the case of the pharmacy privatization program, the focus has been on local demonstration rather than on national-level restructuring. This is changing. The results growing out of the demonstration work have the potential to be replicated on a national level. To do so, the Mission and the Abt team need to reexamine their respective roles in project management. While the Abt team has been successful in replicating results at the oblast level, national-level changes in Kazakhstan will require a different level of general support. Opponents of national-level reform are more deeply entrenched than their local-level counterparts, many of whom accepted change begrudgingly.

The contractor should not feel that it is ceding control of the project by working even more closely with the Mission when dealing with national-level issues. In the case of such issues, the Mission has a larger role. It is important that the host governments understand that the United States is firmly behind the reform of the health care sector. They need to know that the U.S. government continues to see health care reform as directly affecting the overall transition process. Unless the general public believes that the governments of Central Asia are committed to maintaining the social safety net, the overall transition could falter.

There are a number of ways that the Mission and the Abt team could meet this challenge.

1. As negotiations move to the national level to roll out any of the programs developed under the project, the Mission should continue to play a leading role in the discussions. If problems develop, it is likely that the imprimatur of the U.S. government on any reform would greatly increase the chance of its adoption. Within the IDSs, Abt has relied on the logic of its technical advice to stimulate real reform. As the project moves to the national level, the technical advice may need the political weight of the U.S. government.
2. Consistent with the support noted above, the Mission should capitalize on every available opportunity to associate itself with the reform effort. USAID and embassy staff should make highly visible visits to oblasts where important work is underway. Cooperating officials and people aware of the project see the effort as an Abt undertaking rather than as part of the overall U.S. effort in Central Asia.
3. Signing ceremonies, grant award ceremonies, and like project events should involve USAID and embassy participation as another way to support the overall reform effort and indicate that the U.S. government sees the project as central to transition and stability.
4. The Mission, working with Abt, should undertake a media campaign to get out the message that the reform is succeeding and that the American people support the people of Central Asia throughout the reform effort.

As noted previously, the time horizon for the project is relatively short: two more years on the contract and five on the overall economic assistance program to Central Asia. Abt has succeeded in cutting its program losses when specific interventions failed to develop as planned. At the same time, the contractor has been able to take advantage of unexpected opportunities when officials presented innovative ideas for health care reform. As stated above, this flexibility has been a defining aspect of successful project design, but with this flexibility comes the potential to take on too much. In fact, even though the project's several subactivities appear to be related to the reform agenda, they do not all carry equal weight.

The contractor needs to consider carefully each new activity and rank it in accordance with its potential to alter the health care system. The likely time left on the project points to greater concentration on the most productive interventions and their potential roll out. Abt has done an exceptionally good job coordinating other donor efforts in the health care sector in Central Asia. The USAID Mission and government officials interviewed by the team all commented favorably on Abt's important coordination role. Abt has used its donor contacts as a way of laying off some of the project's specific work on other donors. Yet, Abt is experiencing increased pressure to do more as the project matures. Abt must guard against the risk of becoming too diffused and unfocused.

The structure of the project, however, is such that a "cookie-cutter" approach is not appropriate. Each site is different and each country is a unique reform environment. The contract team is the best judge of what should and should not be considered for inclusion in the project. The Mission's role

should be to remind Abt of the critical time frame in which the project operates. At the same time, the Mission should encourage Abt to make its strategic impact requirements the foremost consideration when selecting specific interventions.

As this annex demonstrates, there are already many valuable lessons to be learned from the work underway in Central Asia. The project has been the catalyst for the sharing of information among and demonstrations within the Central Asian countries. The team found less sharing between ZdravReform in Central Asia and the Ukraine and Russia projects. Abt/Bethesda, USAID/Washington, each of the Abt field offices, and, probably most important, each of the regional missions should address this shortcoming, for there is much to be learned from the project. A determined effort is needed to increase communication among Almaty, Kyiv, and Moscow. Staffs and counterparts should be making intercountry site visits. Regional topic-specific conferences should be encouraged, and lessons learned should be widely shared to increase awareness of successes and to assure those who have to make health care reform a reality in their respective countries that they are not traveling the path alone.

VI. RECOMMENDATIONS

A. Project Design

1. The Abt contract should be funded for the last two years of the project.
2. The Mission should continue to keep health care reform a top priority in the various national policy dialogues in which it is engaged. The Mission should continue to emphasize the relationship between successful reform in the health care sector and overall economic transition.
3. The Abt field team, with USAID support, has done an exceptionally good job of managing the reform process at the oblast level and, in the case of pharmaceutical privatization, at the national level. As the Mission begins to expand on the lessons learned and makes those lessons part of its national policy dialogue, its role will likewise have to expand to even greater involvement in the health care reform process.
4. The ZdravReform program is encouraging civic participation and choice within the health care system by using voluntary nongovernmental forms of organization. The Mission should explore ways to coordinate its other ongoing civil society programs with the ZdravReform efforts.

B. Project Management

1. The current operational management model requiring detailed Washington/Bethesda concurrence should be altered to streamline communication to move project implementation along as quickly as possible.
2. As management shifts occur, the Almaty Mission, the Almaty Abt team, USAID/Washington, and Abt/Bethesda should look to new concepts of virtual team management to speed project implementation of ZdravReform. Resources should be made available through the Management Bureau to assist in such an effort.
3. As the project matures and moves to new regions and functional areas, the management demands on the Abt team in Almaty will grow. The team needs to prioritize these demands and accompanying subunits of activity to ensure that it concentrates on the most important issues.
4. Much greater emphasis needs to be placed on sharing with the NIS the experiences gained under the project. The two CD-ROM projects underway will assist in information dissemination, but field visits to sites in Russia, Central Asia, and Ukraine should be encouraged to promote cross-fertilization of ideas and strategies, especially those relating to FGPs, clinical training, information systems, and licensing and accreditation.

5. The Abt team and the Mission should increase the mass media coverage devoted to the project. The successes of the Kazak and Kyrgyz IDSs should be promoted more widely to demonstrate the value of ZdravReform.

C. Clinical Issues

1. As the clinical training program expands, STLI (Kyrgyz Republic), the Almaty Medical Institute, and the Kazak Postgraduate Institute for Physicians will benefit from collaboration with outside institutions, professional societies, and private voluntary organizations. The project should solicit RFPs from such groups, possibly on a competitive-bidding basis, for both short- and long-term clinical training strategies and implementation. These projects should also aim for competencies in support of board certification in family practice, thereby enhancing the status of such practitioners.
2. The project should continue to support the STLI efforts at the national level once the STLI relocates to Bishkek.
3. Before the training activities accelerate, the source of technical assistance to the training program should institute a plan for teaching the methodology of instruction. Training of trainers should not be limited to course content but rather should also include techniques on adult learning styles, group dynamics, presentation styles by instructors, development and use of audio-visual materials, course competency testing, and early identification of learning barriers.
4. The project should require clinical training to be complemented by instruction in patient-focused care. Such training is an integral component of reform. Once competition in the health care sector becomes more apparent in the market economy, patient perception of competence will be a major factor in patient satisfaction with the overall health care system.
5. The project should strengthen the role of the primary care nurse. Given the present shortage of family doctors and the availability of nurses, a refresher training course may extend the utility of the doctor at family medicine clinics. The project should also explore the role of primary care nurses with the Departments of Nursing at the Almaty and Bishkek Medical Institutes.
6. The project needs to develop curricula that include basic CPR instruction for both nurses and doctors. Consideration should be given to a problem-oriented approach (differential diagnosis versus specialty topics) in didactic sessions and to increased opportunities for bedside teaching. The most valuable interchange will come from examination of the teaching advances in the IDS in the Kyrgyz Republic.

7. The project should ensure the availability of basic equipment such as otoscopes and ophthalmoscopes, eye charts, growth charts (National Center for Health Statistics [NCHS] standards), basic diagnostic laboratory tools (dip sticks), and glucometers. Patient education sheets in Kazak/Kyrgyz would be helpful. Equipment distribution for FGPs should be completed so that training has relevance and immediate applicability.
8. For better monitoring of health events, the project should promote use of the international growth standard in the “Road to Health” growth charts in the medical record systems for pediatric populations.
9. The project should upgrade medical record keeping by using the SOAP (subjective, objective, assessment, and plan) method, problem lists, immunization sheets, medication logs, and patient and family history sheets.
10. Laboratory services to support FGPs need to be developed. A small grant could allow private enterprise to start a courier service for transporting specimens to larger laboratory facilities and transporting results back to providers in a timely fashion.
11. The project should consider using the services of a local survey-experienced group to conduct periodic patient satisfaction surveys. Surveys allow for quick assessments of and course corrections within experimental models of health care service delivery.
12. Given that FGPs are asking to deliver vaccinations as a basic health service (logistics may be problematic), dialogue needs to begin with local health authorities to clarify how vaccinations will be distributed.
13. Oblast health authorities need to make basic formulary decisions as well as decisions related to pharmaceutical procurement and distribution to ensure that each FGP has a supply of essential emergency drugs.
14. The government should consider linking water and sanitation projects with ambulatory health care training.
15. The project should selectively invite counterparts to participate in U.S. study tours and clearly define trip objectives and the expected application of lessons once participants return to Central Asia.

D. Quality Assurance

1. Given strong MIS, the project should move from a QA to a QI mindset by developing and prioritizing health indicators as well as process and outcome measures.
2. The project should collaborate with the oblast-level QA Committee to identify specific, actionable QI projects that will ease the transition from QA to QI. Moreover, the project should strengthen the QA Committee by helping it prioritize key quality indicators, targets of utilization, and benchmarks.
3. The project should begin exploring how profiling of providers and facilities will increase interest in QI measurement and link measures of quality with costs to generate support for the utility of the QA/QI efforts. The project should experiment with the means to make provider profiling a basis for incentives in at least two ways: by exploring the usefulness of practice managers' feedback to FGPs and by disseminating FGP performance for benchmarking within the FGP associations.
4. The project should build on the foundation of the clinical effectiveness workshop in Kazakhstan to develop practice parameters. By providing access to evidence-based medicine and encouraging FGPs to identify focused research projects that demonstrate appropriate processes and outcomes of good medical practice, the project would strengthen the development of clinical guidelines.
5. The project should rank order the diagnoses of ambulatory and inpatient cases as a means of focusing on essential clinical pathways and tie these pathways to either process or outcome measures to track whether the pathways are followed and are influencing provider care.
6. The project should establish practice manager positions for the family group practices in Kazakhstan to assist with data entry at the group level and to facilitate immediate feedback for providers.
7. The project should consider enlisting the support of the Sanitary and Epidemiological Service and Peace Corps volunteers already working on oblast health data collection and analyses.
8. The project should determine whether physicians might be interested in studying the cost-effectiveness of home visits (provider time, patient satisfaction), perhaps by investigating an expanded role for visiting nurses. As practices grow, providers may be more inclined or required by circumstances to spend time with patients in the office rather than traveling to homes.

E. Marketing

1. The project should track disenrollment rates from FGPs as well as the reasons for disenrollment.
2. The project should formalize patient and provider satisfaction surveys once FGPs are fully operational.

F. Payment Options

As risk-sharing arrangements continue to be explored, the project should give careful consideration to the appropriate balance between payee and provider protections.

ANNEX B.1

CENTRAL ASIA—PRIVATIZATION/PHARMACY PROGRAM

I. DRUG POLICY

The full support of the appropriate host government agencies and all drug distributors, pharmacies, and health care principals is vital to the success of the privatization process. All other sectors of the economy must likewise sustain as well as catalyze the process.

The interview with Professor Kelesbek Abdullin, Department of Control Quality and Licensing and Medical Equipment, was a productive exercise. First of all, Dr. Abdullin paid high compliments to Abt Associates, indicating his satisfaction with the current 80 percent privatization of the pharmacy industry, the implementation of the Essential Drug List, the formulary process still undergoing development, the drug procurement tenders process that has been introduced, the drug information booklet planned for November release to support the Essential Drug List, the reimbursement structure that is being introduced, the proposed drug system management training program scheduled for near-term introduction, and the recommendations for quality control.

Given Professor Abdullin's position as a top Ministry of Health official, it appears that the MOH is in full support of the privatization process. The professor stressed that the privatization effort could not have progressed to its current position if left to the government or some other available resources. He also indicated that the process will sustain itself in response to a solid in-place structure. The probability of sustainability is even greater in the context of other activities that fully support the privatization efforts. He further suggested that continued help in reforming minds in tandem with the system is a crucial component in the introduction of new concepts backed by technical training.

Contractor Management Assessments

The drug policy segment of the program seems to have been effectively assessed and managed by securing the best government resource partner and capitalizing on the delivery of technical assistance to the right person at the ministry level. The acceptance of the World Health Organization's (WHO) base drug list proved to be the best strategy for application to the privatization process. The full and continued support of the established seven ministry committees of Dr. Abdullin's bureau will contribute to the sustainability of the drug policy, as strategized by Abt. Interviews with various representatives from government, private enterprise, and state hospitals revealed that the pharmacy privatization process is seen as an expanding operation with the potential to reduce costs and achieve better quality and standardization. Further, the interviewees stated that the Abt-designed communications to the oblasts and private sector have effectively reached their targets.

II. ESSENTIAL DRUG LIST

Creation of the Essential Drug List was a crucial aspect of the privatization program. The previous system accounted for over 700 entries with 3,000 items. It included products covered by entitlement programs designated for large portions of the population. With government funding cut in half and the share of Gross Domestic Product (GDP) allocated to health dropping from 6 percent to 3 percent, the items on the original list were hardly affordable. Moreover, quality control and the availability of generics became additional matters of concern. Narrowing the list and improving quality have increased awareness of the concept of accountability and competition as exemplified by the ease of gaining acceptance of formularies, price reductions, and the tender process.

The Essential Drug List was adopted by national decree in February 1996 and has functioned as a springboard ever since. Dr. Abdullin expressed his pleasure that the recommendations have set the standard for capitalizing on the World Health Organization's drug list, although the WHO list accounts for only 18 percent of the national list. He also indicated that it is much easier to procure items now than a year ago. In addition, competition from multiple sources has led to significantly lower prices. Indeed, competition will increase with the introduction of consistency.

A Pharmacy and Therapeutics Committee (P&T Committee), for which a starting point already exists in the ministry, will guide the consideration of exceptions to the Essential Drug List based on appropriate standards, pricing, and usefulness. The seven committees currently under operation within the MOH are as follows: equipment, nutrition, cosmetics, narcotics, pharmacopeia, pharmacology, and production. It would seem reasonable to use these existing committees in standardizing the Essential Drug List.

Contractor Management Assessments

The process that resulted in development of the Essential Drug List offers a basis for the most important next steps in the overall privatization process. The approach taken by Abt was not only creative but also allowed Kazakhstan to incorporate its own process, lend its support to providing direction, and then position itself as a resource.

III. FORMULARIES

Drug formularies based on the Essential Drug List and the current drug usage of specific hospitals were developed for six facilities and one oblast. The process introduced the concept of a pharmacy and therapeutic committee as well as the concept of drug purchasing based on a therapeutic and economic rationale. While the formularies have been officially adopted by the different facilities, they have been only partially implemented.

Some of the difficulties include the following:

- C In some cases, the privatization and break up of Farmatsia, the national pharmacy, resulted in various unwanted drug stocks being forced on the former Farmatsia pharmacies now assigned to the health facilities. The excess drug stocks were not part of the formulary but needed to be used up.
- C In other cases, the hospital pharmacy was still officially part of Farmatsia; it had not been officially assigned to the hospital yet. Thus, the pharmacy did not have the necessary autonomy to order drugs based on a formulary.
- C Financing caused other problems. The Ministry of Health was closely involved in the drug budget, often paying for a large percent. The hospital would give lists of proposed drugs to the MOH, which might slash the list by 50 percent and then send the list to the Ministry of Finance, which would then make further reductions.

Contractor Management Assessments

ZdravReform did some excellent work in developing and gaining the acceptance of the formulary process in the given facilities. Now ZdravReform staff must monitor the situation concerning formulary implementation and provide assistance as needed. Widespread dissemination of the formulary process should take place. The difficult national financial situation may hinder implementation, but once the formularies are in place, they will represent a serious first step in the rationalization of drugs.

IV. DRUG BENEFITS

To this point, the issue of assessing drug benefits on a direct basis has gone unaddressed. It appears that many other factors must fall in place to create a substantial foundation for change. Any assessments of drug benefits must be linked to the current reform aspects of the specific drug list, formularies, procurement, reimbursements, capacity, capabilities, and all the necessary tools to begin a fully supportable process of analysis and change.

The interview with the chief of staff at the Almaty Pediatric Hospital, Dr. Zhanna Sakenova, touched on the current inconsistencies in the public entitlement drug benefit program. Specifically, the program does not provide free coverage to ambulatory patients over one year of age and thus is just one example of the need to address permanent benefit changes.

Dr. Abdullin indicated with respect to drug benefits that the MOH will be able to support public sector funding through the MHI Fund, though only after a two- to three-year conversion. At that time, the MOH will be able to look to concrete changes in the content of the benefit.

Over the short term, it appears that drug benefits will informally change in response to current reforms that provide indirect benefits of lower production costs resulting from

competition, greater access, higher quality, direct reimbursement through the private sector, and public stabilization.

Shymkent was to be the pilot project that would combine reimbursement and ideal outpatient drug benefit enhancement or reform. The intent was to set up a Medicaid-type program, with the MHI agency handling all invoices from both the private and public sectors and functioning as the sole distribution source for public entitlement patients. However, political instability suggests selection of another IDS before technical assistance, funds, and time run out.

Contractor Management Assessments

The management of the drug benefit effort has received the least direct attention but seems to benefit indirectly from the following: lower prices through tender and direct competition, better access, and improved distribution. It will benefit from other yet-to-be-implemented components as well. The new system's structural shifts will create inherent benefits through process and transition rather than through changing specific benefits to specific beneficiaries. It probably would be prudent to consider a reassessment of location in order to have the time to create a more stable test site that incorporates the process of drug benefit development.

V. DRUG PROCUREMENT

A system has been implemented to address a tender or bid program as a means of developing a process that is as competitive as possible. The program is being instituted through the model program with the wholesale distributors and has not yet been brought down to the retail level. The tendering or bidding process demonstrated that the first bid amounted to a 90 percent award to the private sector and a 10 percent award to the state-owned facility for a major purchase of Essential Drug List products now available and more affordable to the state program through hospitals, state pharmacies, and private pharmacies.

Comments offered by hosts and Abt staff in several interviews pointed to current inefficiencies and obstacles (20 percent surcharge) to all purchases made by the government outside Kazakhstan. To a large degree, the inefficiencies have been responsible for the higher prices. The tender program could help reform anticompetitive taxation.

VI. DRUG INFORMATION

A careful sequence of events has led to a drug information system fully supported by the host players. Up to this point, Medstandart, a somewhat independent organization with a dotted line to both the Ministry of Health and the National Standards Bureau, represented an obstacle to reform. With its own drug information data, computer capabilities, and publishing capacity, Medstandart has positioned itself to protect its operations. The absorption of Medstandart into the ministry department has removed the organization's

incentive to monopolize data. The Abt-formulated Drug Information Book will provide clear, concise drug monographs on the 300 drugs that have been accepted on the Essential Drug List. This book is slated for completion in November 1996 and will be distributed to over 4,000 health facilities, physicians, and pharmacists. The expectation (although it is unlikely the budget will support such distribution) is for distribution nationally to all health care facilities so that all physicians, pharmacists, and other care givers can use the booklet. It will be revised regularly. The ultimate plan—still years away—is to create a computer databank and, when feasible, distribute diskettes that can be readily updated, thereby reducing overall costs.

The construction of the database has been undertaken by Grace Hafner and Talgat Nurgozhin, both Abt staff, in conformance with the established Essential Drug List. The structure conforms to established standard formats from recognized current national compendia. The goal is to translate the entire database into Russian for complete assimilation.

Contractor Management Assessments

The process of developing the Drug Information Resource Program has been well managed. It was strategically integrated into the Essential Drug List, an earlier process, and the two programs have evolved together naturally. Abt increased local players' recognition of the effort by enhancing its value and creating a sense of ownership. The ministry's Dr. Abdullin, who supports the Drug Information Resource Program, seems eager for the introduction and distribution of the resource product.

VII. DRUG REIMBURSEMENT

The program's drug reimbursement focus has received little attention thus far. Several mixed messages have raised concerns about the design, implementation, technical assistance, and ultimate success of the effort at this time.

The Abt site briefing unveiled a plan for pharmacy reimbursement geared to the entire health care reform system, including the pharmacy sector. The team believes that the plan is beyond the comprehension of the host and certainly the capability of current systems and would require a direct dovetail with the recommended ZdravReform program. The sophistication of the plan and the resulting complexities would seem to be more than anyone could reasonably handle, especially in view of the expected speed of the pharmacy privatization effort coupled with the simultaneous retooling of the pharmaceutical industry.

The interview with Charles Krakoff, Abt senior associate/pharmacy privatization expert, indicated the importance of paying more attention to the regulatory structure, with preliminary work directed to the advancement of new programs or processes. Talapker Imanbayev, general director of the National Offices of the Mandatory Health Insurance Fund, commented that the fund has no interest in the pharmacy reimbursement program and would either address the program in the future or find it not to be an issue for the

MHI. At the same time, Imanbayev noted that the only current interest in pharmacy is related to the diversity of pricing, which can be regulated through claims criteria. It was also pointed out that oblasts such as Semipalatinsk look to cover all facets of health care reimbursements, including pharmacy costs. According to Imanbayev, “They are free to try the process with approval from the national fund.”

Krakoff discussed plans to implement a pilot program on limited reimbursement capacity in two oblasts. The pilot projects would incorporate the treatment of tuberculosis, which has a high incidence in Kazakstan, by using three to four identified drugs from the Essential Drug List and identifying the associated criteria as follows:

- C number of patients in a given area;
- C identification of the recipient’s card number;
- C identification of the number of participating pharmacies;
- C identification of the number of medical providers who can write prescriptions;
- C incentives to eliminate over- and underprescribing;
- C creation of copayment guidelines; and
- C development of capitation parameters.

Abt’s help in establishing a tailor-made design rather than trying to improve a ready-made design would allow for greater replication possibilities. Individual oblasts could address pricing goals as a means of providing greater host understanding and a better endorsement of opportunities, both of which are necessary for local adoption.

The Semipalatinsk interviews with Marina Orazgalieva, director of the Mandatory Health Insurance Fund, revealed that the oblast program is currently making pharmacy reimbursements at 50 percent of the cost of drugs at retail outpatient pharmacies for two classes of patients: pensioners and army veterans. She went on to indicate that the MHI Fund would assume reimbursement in the near future. As substantiated by the general director of the National MHI Fund in Almaty, the activity in Semipalatinsk is unique and has already received MHI Fund approval.

Contractor Management Assessments

A number of inconsistencies relating to what was rolled out at the site briefing, what had been explained during a one-to-one interview, and what was said by the general director of the National Mandatory Insurance Fund created a confusing evaluation. The management of the drug portion of the privatization program may need a second look, not termination. The task should be reevaluated to take into account the above inconsistencies, the nature of the rolling design, and the obstacles to strengthening and enhancing the process. As Krakoff pointed out, the incorporation of a simple program to inaugurate the process at only one or two test sites with the intention of replication on a step basis as new elements are introduced would be an important approach. This simplified step- implementation strategy would allow for the natural growth and enhancement of all health care reform program reimbursement elements and permit components to dovetail with minimum efforts.

VIII. DRUG SYSTEM MANAGEMENT

Given the limited experience with drug system management thus far, the results are necessarily limited. The work plans and task orders seem aggressive and ambitious. “Business Management Assistance to Private Pharmacies Work Plan,” a collaborative program of Abt Associates’s ZdravReform program, Carana Corporation’s Small-Scale Privatization and Enterprise Support Programs, and The Futures Group’s SOMARC Project, has been presented but not yet implemented.

Carana Corporation has been the main technical adviser to the Kazakhstan government for the Small-Scale Privatization Program. It has also assisted territorial committees of the State Property Management Committee (GKM) and the State Privatization Committee (GKP) in both preparing retail pharmacies for auction and conducting the auctions. Carana is beginning to analyze the effect of privatization on the pharmacy sector by comparing retail and wholesale prices in state-owned pharmacies (those still operating) with those in privately owned pharmacies. Although unable to interview Carana directly, the team learned that some price comparisons represent reductions of 150 percent.

The Futures Group, through its SOMARC Project, is developing a national market for contraceptive products; carrying out contraceptive marketing, communications, and training programs; and working with individual pharmaceutical importers, distributors, and retailers to develop and strengthen regional and national distribution chains for contraceptives. From a conversation with Don Ruschman, regional manager, Central Asian Republics, it seemed that the introduction of management programs could be enhanced through a franchising program. The program would be structured around a chain-type retail business through individual ownership but under a single banner for volume purchasing, marketing identity, and scale economies. This process was not included in the project’s initial scope of work. From Abt’s point of view, it was part of the rolling design plan.

Working through SOMARC, Don Elliot, senior consultant, pharmacy sector, International Executive Service Corps, indicated that he has been developing a technical training and initiation program. He is taking it to various pharmacy owners to begin implementing business management and marketing training and developing the retail skills of the new owners. Taken together, the training should help strengthen the results of the SOMARC contraceptive initiatives.

Krakoff provided the team with the following material that he secured from E. Petrich and Associates, Inc: Personnel Management Systems and Assessment/Development of Market Research Capacity for Private Pharmacies. He secured these manuals for review and possible inclusion in developing the managerial training material under the Drug System Management Program. In addition, he indicated that a manual for drugstore management and marketing skills would be available through the efforts of The Futures Group, and, through collaboration, a training course could be developed and targeted to

designated individual model stores or multiownership unit models through the development of criteria.

Contractor Management Assessments

The Drug System Management Program seems to be in its formative stages as well as in a rolling design format. Its multiple sponsors, common goals, and various elements could potentially be brought together with a multiple-benefit prospect, although details as to oversight responsibility, day-to-day management, and host models would have to be specified.

The management skills of Abt in this phase of the designated task are unclear given the absence of a working sample or a definite selection of training tools. The material provided as training tool manuals is undergoing evaluation.

IX. QUALITY ASSURANCE

Quality assurance has not been formally addressed yet. The task has been substantiated in many interviews and conversations but has been commonly and frequently alluded to as a future consideration for the overall durability, continuation, and, ultimately, sustainability and success of the program. Quality assurance is a prominent consideration that can take its place alongside current reengineering, but its permanent place needs to be identified if long-term quality measures are to become credible in supporting the reform program.

X. PHARMACY SITE VISITS

The team made a number of unannounced pharmacy site visits to examine the various phases of the privatization process thus far. The team had difficulty engaging participants in nonofficial interviews. The first pharmacy was a modern, postprivatization facility located in the central area of Almaty. It was well staffed and reflected excellent merchandising techniques. Its open displays revealed a wide variety of medical and nonmedical products as well as many prescription products. In addition, products were well integrated with different specialty sections and large amounts of shelf, counter, and wall advertising, which included prominent displays of the SOMARC contraceptive material.

The other site visits were the normal and almost expected variety in Almaty. The next facility was still state-owned and austere, with everything hidden in cabinets or sparsely arrayed on an open display shelf. No merchandising of any type, no advertising, and no over-the-counter products were visible. One white-coated individual was visible. No cash register was apparent.

Abt then arranged for the team to visit different operational levels of pharmacies. The next pharmacy was in more of a suburban area near the outskirts of town on the first floor of an apartment building. It possessed elements of both modern and state-operated facilities. It had advertising in several locations around the room and seemed to have

modern cabinets as well as medicinal and non-medicinal merchandise in open view. The team was invited behind the counter to the compounding and storage rooms and the office. The facility was well organized and well laid out. It had been purchased several months ago and had undergone refurbishment, which was reflected in the staff's pride in the conversion from the old to the new.

The next location was a state-owned pharmacy recently purchased by the SibPharm Wholesale/Distribution Company of Novosibirsk and slated to become a model for the Drug Systems Management Program. The facility occupied a large portion of the street-level floor of an apartment building and had a huge area for merchandising. It also had a similarly sized basement that will be converted to a SibPharm Wholesale facility. The pharmacy was producing some products and had various pieces of equipment for sterilization and compounding and evidenced limited manufacturing capability. The pharmacy had not changed much since SibPharm's purchase. However, a limited number of new products has been introduced; sales, low at the start, had more than doubled. The interview with Victor Grunsky, director for SibPharm in Almaty and the guide for this pharmacy visit, was eager for the start of the "Model Pharmacy" program, the recommendations for remodeling, and merchandising and marketing training opportunities.

The next set of pharmacies on the site visit were located in Semipalatinsk and owned by the Romat Wholesale/Distribution Company. Romat bought 18 auctioned pharmacies and now has about 30 retail locations. The visit to two of the company's outlets revealed clean facilities with new fixtures and a merchandising methodology. Signs, open displays, cash registers, large outside lighted signs, and well-organized interiors were noteworthy features.

Turarbek Rakishev, the owner of the Romat Company, indicated that Romat is a conglomerate made up of a manufacturing component, a wholesale/distribution business, and a retail division of 30 pharmacies. The company is going to manage all three components and eventually concentrate more on the production or manufacturing program. Rakishev also mentioned the possibility of establishing a franchising program for the retail outlets, allowing for expansion but without the individual ownership process that is now required.

The interviews generated several references to franchising, a prospect currently undergoing exploration by SOMARC and an expert consultant who has been brought in to help determine its feasibility. The team spoke to James McGinnis, vice president, training and development, Sizzler International, Inc., who has been in contact with many of the principal players and has noted considerable interest in franchising.

XI. ABT PHARMACY PROGRAM MANAGEMENT SUMMARY COMMENTS

Based on interviews and observations in Kazakstan, Abt Associates's management of the pharmacy privatization program appears to have been effective. Abt field personnel

demonstrated a management style that functioned as a building block for most of the critical elements addressed.

The program seemed to be divided into eight major categories as follows:

1. Drug Policies
2. Essential Drug List
3. Formularies
4. Drug Information
5. Drug Procurement
6. Drug Reimbursements
7. Drug System Management
8. Quality Assurance

The Abt management strategy started at ground zero by helping directly and dealing with the foundation of the whole process relative to basic drug policy issues. Abt initiated the process at the ministry level with recommendations and samples of declarations, which then focused the attention of the ministry on the development of mandates. Abt effectively directed its efforts at the ministry by exploring the potential use of the WHO drug list drug selection criteria as the baseline for the Kazakstan Essential Drug List. The ministry adapted the list and produced a pared down Essential Drug List that became a national mandate. The list functioned as the major building block for reform of the formulary, drug policy, drug information documents, and drug procurement. The management system seemed to incorporate the right balance of process to achieve the most desirable outcomes.

Other program elements may have propelled Abt into areas that may be more involved and complex than the host is prepared for or that the system is ready to address. Addressing these elements may cause more complications than exposure would warrant. Management adaptation might be considered for revision to or reassessment of the following: drug reimbursement, drug system management, and quality assurance. The program may not be ready at this point to incorporate these more advanced processes without first fully implementing the privatization program. Better yet, the hosts might be better able to determine their own capacities to embark on additional tangent elements with the available Abt expertise at the right time and the right place.

XII. DESIGN ASPECT

The project design and responsiveness of Abt to a rolling design process has succeeded. Using the IDS concept where practical seemed justifiable. The drug policies, Essential Drug List, formulary concept, and drug information pamphlet have all worked as well as could be expected and probably better as examples. The overall privatization effort seems to have advanced significantly, with most host comments reflecting how much faster and further the program has succeeded with Abt's technical assistance and invited interventions. Results in the form of lower prices, competition, and a more concentrated

opportunity for beneficial procurement are examples of the incentive process at work, as reflected thus far in the assets of privatization.

Admittedly, the design has not been without gaps, particularly as relates to training and modeling for drug system management. These efforts have tended to follow an ad hoc approach. The same probably can be said of equipment.

XIII. THE FUTURE

The ongoing program of pharmacy industry privatization offers considerable promise, provided the unknowns fall into place. Will the government survive, will the country avoid bankruptcy, will the economy flourish, will the democratic process succeed, and can the past be left behind? The programs are gaining acceptance, enthusiasm is prevalent. Existing government support is apparent. The rolling design capability allows the government to step up or step back as needed and could be instrumental in achieving success. There seems to be a will to succeed.

The sustainability of reform depends on overcoming resistance to change. If people can derive the intended benefits, the results should provide sufficient motivation to sustain the reform process.

The above assessment addresses issues related not only to maintaining but also to enhancing the quality of the proposed interventions. After exposure to the program, the team is thoroughly convinced that the prospects for the future are achievable and that, with the right assistance, reform can continue.

ANNEX C

UKRAINE

I. OVERVIEW

Since 1991, Ukraine has been progressing from a centralized economy and authoritarian political system to a pluralistic society and market-oriented economy. It is developing legal and organizational structures that will provide the basis for a national economy. Currently, the government of Ukraine is experiencing economic hardship and dislocation resulting from the breakdown of ties with the former Soviet Union and the absence of a new, well-functioning system. This breakdown is especially apparent in the case of the Ukrainian health care system, which has been underfunded for several years and, in 1996, was operating under catastrophically low budget levels.

Discussion in Ukraine over the past five years has focused on how the health care system and the social benefit structure might be reformed. The Basic Health Insurance Law passed in 1992 outlines in general terms the government's policy on the guarantee of health care for its citizens and the fundamental relationships of health care administrative and delivery structures, payment, and regulation. The 1993 Law on Social Insurance provides general policy on supplemental safety net programs, including that related to pensions, unemployment, disability, sick leave, and the responsibilities of government and employers. Both laws underscore the government of Ukraine's strong commitment to providing health care to all citizens and protecting vulnerable populations during difficult economic conditions. Several draft policies on health care reform based on mandatory health insurance have been circulated and discussed with the Supreme Rada (parliament of Ukraine) but have not passed. During summer 1996, the constitution of Ukraine was passed, reiterating in Article 49 the government's belief that health care should be available free of charge for all citizens within the existing network of state-run facilities.

Unfortunately, the government of Ukraine does not seem able to support a comprehensive social safety net directly from the national budget as it did under the Soviet Union. Since 1994, state funding for health care has declined. In particular, funding dropped precipitously during 1996 (3 percent of GDP in 1996; in 1992, it was estimated that Ukraine spent a total of 7.7 percent of GDP on the health care sector). While oblast-level health administrators clearly recognize the need for undertaking systemic financing and service delivery reforms, their efforts have been thwarted by national-level proscriptions. For example, Article 49 of the new constitution of Ukraine, which declared that health care shall be free and that the current capacity of the health care system shall not be reduced, led to confusion and concern among local officials and providers about the legality of market-oriented user fees (a beneficial new income source for the impoverished health care system) and the ongoing restructuring of excess bed and facility capacity to increase efficiency. These activities, vital to reform of the system, ground to a halt for a number of months before the Cabinet of Ministers issued a decree further defining acceptable user fees. Local health administrations are still prohibited from officially closing beds or facilities, regardless of the sharp declines in funding for these facilities. As part of the legacy of the centrally planned, "norm-driven"

Soviet Union, Ukraine's health care system emphasized tertiary care and, as a result, can point to an overabundance of hospitals and hospital beds. Thus, the prohibition against the outright closing of facilities prevents local health care systems from realizing savings associated with reductions in personnel or fixed energy costs. The local health care systems are, however, authorized to restructure the services provided within facilities (reduced or redesignated beds).

Overall, the health care system has only limited capacity to finance costs from efficiency savings. New funds need to be found. To do so through a new tax, however, is problematic. The tax burden on employers is currently inordinately high. A 52 percent surcharge on labor funds social benefits, with 12 percent allocated to the Chernobyl Victims Fund and 30 percent to the pension fund. Many employers (including public facilities) are unable to pay these taxes. In fact, smaller private companies pay employees higher rates under the table to avoid taxation for social benefits. High social benefit taxes do not encourage industries to take on additional employees. In addition, the tax rate on corporate profits (up to 80 percent) has discouraged the creation of private health care facilities and practices. At the same time, however, patients in Ukraine have always paid informally (in cash and gifts) for preferential medical treatment and continue to do so today. This "informal" revenue, if legalized as "user fees" or "out-of-pocket payments" for services, could serve as a desperately needed source of funds generated by those citizens who are able to pay, thereby enabling the state to allocate budget funds to those citizens too impoverished to pay for health care.

To date, the Ministry of Health has not been successful in either outlining a general strategy for reforming the health care system or exploring new and legal sources of revenue. Part of the problem is attributed to political instability. Over the past two years, six successive ministers of health have been appointed and sacked. The nearly constant turnover has eliminated any possibility of ongoing dialogue with the ministry. Further, official positions have been nebulous and inconsistent. During mid-1996, Dr. Andrei Serdyuk was appointed Minister of Health. He has since issued some initial statements signaling his support of health care reform. In addition, recent discussions with government officials have disclosed a new interest in receiving assistance and engaging in consultations on developing a nationwide strategy for health care. Indications suggest that the government can no longer deny the current health care crisis. While officials express an interest in the Mandatory Health Insurance Fund set up in Russia in 1993, they are quick to emphasize that a centralized system is required (to maintain control at the national level) to avoid the mistake Russia made when it decentralized health care financing and delivery to the oblast level.

It is too early to tell whether the Ministry of Health will alter its conservative approach to health care reform. In September 1996, however, the Cabinet of Ministers issued a decree allowing user fees to be charged for certain health care services in recognition that facilities must be able to make up for budget shortfalls. Minister Serdyuk has stated publicly that government attitudes toward user fees and reform must change, thereby indicating a growing understanding that the government of Ukraine is unable to support comprehensive, universal health care in an era of declining budgets.

Until now, tangible reforms have taken place at the facility, rayon, and oblast levels. The technical assistance strategy for the two intensive demonstration sites identified in Odessa and Lviv grew out of the collaborative efforts of ZdravReform and USAID/Kyiv during early 1995. The Abt/USAID team selected two sites based on the following criteria: the level of commitment shown by the local leadership in reforming the health care system; the level of ongoing innovative activity; and the overall climate for reform within the oblast.

The Odessa activities emphasize new financing approaches and include technical assistance for business planning, marketing, financial management, and contracting for a managed care entity at the Family Health Center; assessment of and assistance to self-financing facilities and roll out to additional pilot sites; and support of pilot sites in the use of financial management and organizational tools.

In Lviv, activities are improving service delivery, facilitating a shift from in- to outpatient care, emphasizing primary care, linking physician incentives and quality, and introducing financial and management tools. To date, the program has advised counterparts on using cost center accounting, control, and management techniques to identify costs and develop fee schedules for selected services; deriving estimates for an overall facility-level budget; introducing clinical pathways to reduce the length of inpatient stay; restructuring facilities and reassigning staff within rayons to preserve access to care and reduce facilities' variable costs; and equipping, retraining, and reorienting physicians in terms of updated primary care skills.

To date, the ZdravReform program has focused greatest attention on developing the pilot sites in Odessa and Lviv and organizing a series of workshops and roundtables to disseminate lessons learned. In addition, several national-level initiatives have been reactivated this year at the request of the Ministry of Health, including development of a pilot program for facility accreditation, providing assistance to the national strategy to promote family medicine, and assessing a proposal for a managed care initiative with the National Railroad Health Service. ZdravReform continues to develop health management and economics curricula and presentation techniques in collaboration with the faculties of the Odessa and Lviv Medical Institutes and the Kyiv School of Public Health Administration.

II. HEALTH CARE FINANCING

A. Background

The Gross Domestic Product (GDP) of Ukraine is shrinking. According to one estimate, the 1996 GDP is 50 percent of 1991 GDP. The steep decline has compromised the government's ability to mobilize resources for the national budget and has resulted in a serious budget deficit. The government is not paying people on a timely basis; payments for medical facilities are sometimes delayed by as much as six months. In fact, the government has not made payments to health care facilities for items other than salaries for the entire year. Inflation is high and benefits are not indexed to inflation. In addition, the government no longer follows the practice of paying doctors for twice the number of hours worked.

The budget dedicated to health care has been reduced from an estimated 5 percent of GDP in 1991 to 3 percent or less of GDP in 1996, representing an effective 70 percent reduction in the budget directed to health care (not including inflation adjustments) (see below).

1991 GDP assumed to be 100%, with 5% of GDP directed to health care
 1996 GDP assumed to be 50% of 1991 GDP, with 3% of 1996 GDP directed to health care

$$100 * 5\% = 5\%$$

$$100 * 1/2 * 3\% = 1.5\%$$

$$(5\% - 1.5\%) / 5\% = 70\% \text{ reduction}$$

The current situation promotes an underground economy. In the health care sector, the emergence of unapproved incentive payment systems builds on the traditional envelope payments for physician services and other creative charges such as hospital access fees for new fathers to see their wives and newborns, fees for nursing care, etc. Patients are often required to buy their own drugs. Institutions are also establishing fees for traditional services. An interview with a chief physician of a rural rayon hospital revealed that barter is also used as a form of payment when currency is not an option.

The current system is overbedded and characterized by an excess of doctors and other health care providers.

Population in millions	51.3
Population decrease (1994 to 1995)	- 4.6%
Number of physicians per 10,000 population	57.7
Estimated total number of physicians	296,000
Estimated hospital beds per 10,000 population	46.7
Total number of hospital beds *	239,615
Average patients per doctor	173

* Includes only oblast, rayon, district, and daycare beds; may not include military, railroad, enterprise, and KGB beds.

With 12 medical universities in the country, it is estimated that at least 3,000 new physicians graduate each year, creating even greater capacity in the system.

Until 1991, Moscow directed much of the health care financing decision making; local decision making was not part of the system. The in-place accounting systems reported basic data, which were then manipulated to get the “right” results. Efforts to reform payment systems have met with either little activity or outright resistance. Understandably, a procession of six ministers of health over the past two years has translated into a lack of continuity and the inability to establish a consistent program. The recently enacted constitution’s Article 49 further calls into question the efficacy of the government’s efforts to reform the payment system.

The tax rates are extremely high: 52 percent on salaries and 20 percent VAT on goods and services. Profits for private health care are limited to 15 percent. It appears that, as one might expect, individual recipients do not declare most under-the-table health care payments.

The health care system in Ukraine is highly complex. In addition to the state-run system of care that involves municipal and oblast organizations, other systems of care include military, railroad, enterprise, KGB, and private clinics. The delivery of care is organized on ambulatory, ambulance, and inpatient levels, with professional support available at all levels. It is interesting to note that the ambulance system employs its own provider staff and often delivers care on demand at the home. In fact, a patient can order intravenous care from the ambulance service. Not much activity has been directed to understanding and possibly reforming the interrelationships among the multiple systems.

B. Provider Payments and Health Insurance

Based on observations made in Odessa, the intensive demonstration site concept is clearly making an impact. The Abt staff has developed strong contacts in government, hospitals, polyclinics, and academic institutions. The national government has endorsed model activities and subprojects that are being implemented at many sites. The depth of contacts is clearly greater among on-site versus visiting staff.

Objectives for financial reform in Odessa include the following:

- C Product 1: to develop a prepaid group practice demonstration
- C Product 2: to develop a model self-financing system; and
- C Product 3: to develop an overhauled payment and management system.

Objectives for financial reform in Lviv include the following:

- C Product 1: to strengthen the primary care delivery system (similar to the financial objectives in Odessa for Products 2 and 3);
- C Product 2: to streamline the hospital system in Zhovkva (similar to the financial objectives in Odessa for Products 2 and 3);
- C Product 3: to overhaul payment and management systems in pilot facilities (similar to the financial objectives in Odessa for Product 3); and
- C Product 4: to complete partial privatization of a pilot facility (similar to the financial objectives in Odessa for Product 3).

Objectives for national health policy include the following:

- C to review health insurance legislation;
- C to promote a health study tour; and
- C to develop health economics and insurance courses.

As stated previously, the local initiatives seem to offer significant potential for catalyzing reform. Local groups are enthusiastically using the tools provided by the project to implement models. In interviews, the counterparts demonstrated the use of the charge system and the budgeting tools. At the universities, the faculty discussed the impact of project-provided information on the curricula. A university in Kyiv offers a new master's

degree in health administration in response to assistance provided by USAID. In Odessa, recently developed workshop materials are used in university medical training. It was noted several times that the medical professionals must undergo a change in mentality that reflects the adoption of Western methods. The presentation of alternatives was an important step in the process of reform. One concern in the education system is the capacity to train health care administrators. Both the Kyiv and Odessa programs train only a few students for advanced degrees in health care administration (40 per year in Kyiv and 20+ in Odessa). In addition, the curriculum for medical doctors does not focus on health care administration. To promote change among both new and existing medical professionals, adult and continuing education programs should be developed and supported.

The Abt staff also provided information to the evaluation team on three insurance reform pilot programs: two private enterprise insurance programs that paid polyclinics directly for services, one in Dnepropetrovsk and one in Odessa; and a proposal to insure railroad workers throughout Ukraine. The experiment in Dnepropetrovsk worked for a short period of time. A family practice-based clinic received a prepayment for care from certain enterprises located in the area. Enterprise funding has failed in recent months, however, because of severe economic pressures. Like many other providers throughout Ukraine, the clinic has not received payment for services performed. The experiment in Odessa focused on a family planning clinic that received prepayments for services. It was a small-scale project. The government investigated the arrangement and determined that the clinic needed to qualify as an insurance company and needed an estimated \$100,000 of equity to underwrite the contract. The clinic could not come up with the needed equity and has suspended insurance operations. The railroad pilot program was developed and is currently under consideration, even though the railroad has its own health care system. It is estimated that the railroad employs approximately 1 million people, or approximately almost 2 percent of all Ukrainians. Since the population involved is significant, the insurance principles applied to large numbers could provide the basis for an insurance experiment. But the railroad's system competes for scarce health care resources and could further complicate the overall health care system, possibly by indirectly subsidizing the railroad at the expense of other enterprise and government programs.

C. Conclusions

It is clear that Ukraine's health care system has excess capacity. There are too many physicians and too many hospital beds as well as competing systems of care (government, enterprise, military, etc.). Abt staff observed that many individuals simply assume the delivery of on-demand care, especially in the case of ambulance services. The government does not have sufficient resources to maintain the current system. Since payments are in arrears, more and more providers are forced to consider fees for service either through technically illegal facility-authorized charges or under-the-table charges. The education system is continuing to provide an oversupply of doctors, especially in the area of specialty care. The adult education essential to providing the needed "change in mentality" is underdeveloped and has not spread to all oblasts. MIS systems have not been developed to assist in the management functions necessary to operate an enterprise business. Current efforts to use microcomputers would be considered inadequate for Western facilities, which

have advanced to next-generation MIS. National standards such as health laws, insurance laws, and rules and regulations for administering the laws are nonexistent or inadequate and will cause significant variation in the short run. The current reporting of results for the health care system operates on an extremely basic level and will not change unless national or oblast initiatives are pursued. Staff work focused on the local level may be limited in its usefulness as a result.

The evaluation team reviewed an example of these limitations in Odessa. The Abt staff developed a system to identify a limited number of procedures to develop costs and charge data. It was not referenced to a system such as CPT4, which U.S. medical professionals use to bill individuals or payors. At this time, there is no suggested standard. While many procedures will be the same, experience from another system (e.g., the United States or Germany) cannot be used to avoid the growing pains other systems have already experienced. Many procedures defined by the U.S. system are not currently performed in Ukraine and may not be for some time. But the implementation of open heart surgery in Lviv is an example of how technology can change circumstances rapidly. Certain sophisticated procedures will be performed and should be recorded properly for analysis and complete reporting of activities.

III. SERVICE DELIVERY

A. The Health Status Context

With a population of almost 52 million, Ukraine faces a number of public health concerns: the infant mortality rate is 13 to 15 per 1,000 live births (United States is nine per 1,000), the abortion rate is 155 per 1,000 live births, and the maternal mortality rate is 32 per 100,000 live births (Canada is four per 100,000). Deaths exceed births. There is an increased incidence of vaccine-preventable diseases, with higher rates of tuberculosis and other respiratory diseases leading the list of incident cases each year. Although circulatory disorders (including acute myocardial infarctions [AMI] and cerebro-vascular accidents [CVA]) lead the list for hospitalization, the average length of stay is three times that of the United States. Health care expenditures are 2 to 3 percent of GDP (the United States spends 13 to 14 percent of GDP on health care). Each of the 12 medical schools graduates 700 to 800 students per year, although plans call for reducing student intake.

B. Health Care Delivery

The several components of any health care delivery system must work together to ensure the system's proper operation. Some systems lay foundations at a conceptual or policy level; others build on that foundation or add details to the design. The activities of ZdravReform in the Lviv oblast demonstrate these components. Licensing and accreditation lay the policy foundation for rationalization of present health care facilities and facilitate strategic planning for the new health care delivery system. Management and clinical training build on that foundation by instructing new providers and guiding established ones in adapting to the evolving system. Finally, information systems, partnerships, and experimental models of service delivery add the details to the construction of the new health care delivery system.

1. Licensing and Accreditation

In July 1996, with technical assistance from ZdravReform, the MOH issued a decree that a national experiment in the licensing and accreditation (L&A) of Ukrainian health facilities would begin in October following a preparatory phase during the summer. It is notable that the standards are more oriented toward disease outcomes rather than detailed procedures. The experiment identified three oblasts, including Lviv and Odessa, for participation. Thus far, ZdravReform participation has entailed four key activities: the development of draft licensing and accreditation standards in collaboration with the MOH, followed by dissemination of the draft to key Ukrainian counterparts for comment and revision; letters of agreement with pilot hospitals and health facilities; the hiring of a local ZdravReform medical adviser in Lviv to facilitate pilot testing in the IDS (ZdravReform has a medical adviser in Kyiv to support both the national- and oblast-level activities); and participation as a member of the National Board on Licensing and Accreditation.

The value of such an experiment in L&A by the MOH in collaboration with ZdravReform is threefold: as a tool for implementing health insurance and new methods of financing (which facilities qualify for insurance payment, what are appropriate price levels for facilities); as an objective means of rationalizing the health care system (whether to close, convert, or restructure a health care facility); and as a first step in a comprehensive national program for quality accreditation. The last is of prime importance to the MOH. To that end, ZdravReform has begun, on an experimental basis, the implementation of standards in Kyiv Main City Hospital #14 and Lviv Oblast Hospital. Such standards will clarify the redistribution of diagnostic services from inpatient to outpatient settings and likely reduce the average length of stay. Based on the results of the experiment, the Cabinet of Ministers will issue an official law on L&A. Therefore, participation by ZdravReform in L&A is pivotal to a national initiative on a quality assurance review of health care facilities and objective decision making about the rationalization of the country's health facilities. ZdravReform's participation can help ensure that budgetary and human resources are used more efficiently and effectively. Results are due by December 1996.

According to MOH counterparts, the remaining issues relate to the MOH's failure to fund a national L&A program and the absence of a law on quality accreditation. Once legislation is in place, a body separate from the MOH will undertake L&A activities. It will be difficult to change the minds of both physicians and local politicians regarding the standards for L&A and the possible consequences of failure to achieve accreditation. Appeals procedures must be in place to review contested accreditation decisions. MOH counterparts claim that the Ministry of Finance (MOF) may oppose such activities, especially as regards restructuring the budgets of facilities that have been upgraded, converted, or even closed. MOH counterparts express concern that quality accreditation should not be tied to health insurance, a mistake reportedly made by other countries. Therefore, ZdravReform will again play a major role in the legislative arena and, when needed, as an arbitrator for sticking points between the MOH and MOF.

2. Training

Because an important objective in the Ukraine ZdravReform strategy is local capacity building, the program includes a major training component partly in response to legal restrictions and partly to stimulate and inform debate about the steps needed for health care reform. With the move toward a market economy and a changing MOH, the role of oblast health administrators has been limited to priority setting and the efficient use of resources. In this regard, the need for planning and evaluation skills is paramount. Therefore, the training activities supported by ZdravReform must focus on management (administrative, financial) and clinical (family medicine) issues. In the first case (management), training is closely integrated with local capacity building for the management of health care financing reform activities. The second (clinical) area of training supports initiatives to remodel the primary health care delivery system, though such initiatives are largely outside the purview of ZdravReform expertise and are addressed by the University of Colorado Family Practice Department volunteers.

Management Training. Now in its third year, the management training offered by the School of Public Health Administration (SPHA), chaired by Ivan Solenko, PhD, has graduated 40 students, with ZdravReform providing some of the instructional and course materials. About 300 registrants have participated in roundtables, seminars, and 34 courses. The European Association of Health Care Management, of which SPHA is a member, has certified the program. In addition, the Cabinet of Ministers has certified the degree program through the Academy of State Administration. Although the SPHA now relies on foreign faculty, it aims to train and employ Ukrainian faculty and use Ukrainian texts—all with a view toward sustainability.

The SPHA, funded by the World Bank during its first two years, would like to expand into other cities, particularly Odessa, but lacks funding to do so. Some of its graduates have completed master's degree-level research on such topics as economic regulation of health care, problems and perspectives of privatization, and insurance options for payment systems. An estimated 12,000 health care managers could benefit from some formal management training. One ZdravReform staff member in Lviv expressed concern that the program content leans toward the theoretical and that graduates of the program do not necessarily enter the public sector; however, he also suggested that young graduates could gain field experience while serving in management positions, particularly if ZdravReform expanded its activities to other oblasts.

Clinical Training—Policy. Clinical training in family medicine is available at both the national and city levels (Lviv IDS). At the national level, ZdravReform has been working with the MOH to increase awareness of the strategic value of family medicine, especially as related to guiding the MOH in retooling, redeploying, and providing incentive compensation to medical personnel within the country as rationalization of health care facilities occurs. A program to increase national awareness of the value of family medicine was the subject of a national roundtable in June 1996. The forum was designed and chaired by the Deputy Minister of Health, thereby indicating the level of importance accorded the meeting. Thirty-three people attended the forum on behalf of various departments of the MOH: the Kyiv Health Administration, the NIH, the Academy of Advanced Medical Studies, USAID, and ZdravReform. Among the several presentations, ZdravReform identified five major areas for

promoting policy reform on family medicine in Ukraine: establishing a legal framework for family medicine; developing appropriate economic incentives to ensure the growth of family medicine; recognizing various organizational settings for family medicine practice; enhancing the business component of family medicine practices, including the implementation of information systems for management, finance, and health indicator tracing systems; and strengthening the family medicine curriculum by including more preventive and screening activities and distinguishing between the needs of urban and rural areas.

One result of the roundtable on family medicine was the creation of a national board on family medicine, with ZdravReform advisers and several IDS counterparts named as members. The board is charged with establishing a legal framework for the first class of family medicine practitioners. At the IDS level, the head of training of family practitioners is working within the Lviv Medical Institute to promote curriculum changes and has thereby gained the support of the institute's director. Moreover, the MOH has requested selected IDS counterparts to prepare background material for family medicine legislation. The information systems components have been the focus of the Odessa IDS, where the Family Health Center has created a financial management system.

Clinical Training (Family Medicine)—Practice. The second training initiative has focused on family medicine. It would appear that the concept of family medicine has existed at least since the early 1980s, at which time Lviv Medical University obtained permission from Moscow for a family medicine curriculum experiment. The head of family medicine training (Dr. Zaremba) began a family medicine retraining program for specialists and then relocated the physicians to rural practices. More recently, volunteers from the University of Colorado (spearheaded by Dr. Jack Reeves) have been working in conjunction with the Lviv family medicine experiment. Despite the efforts of the University of Colorado to develop programs in Lviv, it was only when the director of the ZdravReform IDS in Lviv (John Stevens) contacted the University of Colorado (UCO) that local family medicine training was accelerated for specific sites in Lviv, thereby facilitating the oblast-level strategy in family medical curricula. The UCO activities support the ZdravReform initiatives for family practice within the IDS, although the funding comes from university and private sources.

ZdravReform and the UCO group have worked with Polyclinic #2 and the Lviv City Hospital #1 Family Medicine Group Practice (FM #1) as well as to some extent with Yavoriv, Zhovkva, and Skole, all outside Lviv City. The UCO activities are supported in part by the Nadiya Group, a nonprofit Christian arm of the UCO Department of Family Medicine interested in the Ukrainian health care exchange opportunities. The UCO has investigated the standards of care at these facilities in terms of patient and provider interaction, clinical diagnoses, ancillary support for clinic functioning, and the need for basic equipment at each site. It has also discussed a curriculum for a four-month refresher course, suggesting that its organization should be driven by burden of illness rather than by multispecialty topics. Over 100 practitioners have taken the four-month course, followed by interviews as to the effectiveness of the course and its relevance to the needs of participants' practice.

As for features that would enhance the family medicine group practices, nonrandom interviews indicated that group practices that were separate from polyclinics (specialists)

tended to be more self-reliant and stronger in promoting family medicine and less disposed to making an unnecessary referral to a specialist than those group practices located inside the polyclinic. Moreover, although the physicians were working longer and harder hours, they evidenced a higher level of satisfaction and sense of competency than in the past. They knew their patients better while patients seemed more satisfied with the continuity of care. The latter phenomenon increases the likelihood that patients will refer others to the same group practice, thereby encouraging growth and sustainability of the practice. Continuity of care and familiarity with the provider have led to fewer ambulance calls by patients. Home visits continue to be a part of the practice, although some providers expressed concern over the inefficiency of such endeavors. Nurses could assume some of the burden of house calls, with physicians teaming up for the initial patient evaluation.

Several clinics lack basic laboratory equipment and supplies (microhematocrit centrifuge, microscope, otoscopes, and ophthalmoscopes as well as supplies for testing urine and blood for sugar and protein). In such clinics, doctors even have to share stethoscopes and blood pressure cuffs. Growth charts, infant neurodevelopment charts, vision screening charts, and reference books are also sometimes lacking. The Nadiya Group has provided six sets of otoscopes and ophthalmoscopes and is planning to equip each family medicine graduate with a doctor's bag.

3. Models of Service Delivery

Models of service delivery within the IDS have been developed to varying degrees at four sites: the Family Medicine Clinic in the catchment area of Lviv City Hospital #1; the Department of Surgery within Polyclinic #2; Yavoriv Rayon Health Complex, a recently identified site that is just beginning to develop strategies for service delivery changes; and the rural setting of the Zhovkva Rayon Health Complex (not visited during this evaluation). Although not within the IDS, the innovations of the Dnepropetrovsk Family Medicine Clinic led by Dr. Mostipan deserve mention.

The Family Medicine Clinic (Lviv City Hospital #1 [FM #1]). With six family practitioners serving a 12,000-person catchment area, this model was examined in greater detail than the others and serves as testimony to the dedication and forward thinking of its leadership and staff. Moreover, it provides an example of synergy between ZdravReform and a local health care facility. The following key points illustrate achievements as a product of this synergy:

1. Strategic Planning. Strategic planning provided the foundation for the growth and development of the group practice. A map of the rayon was developed to indicate the geographic challenge and opportunities in serving the catchment area. It illustrates graphically and simply the location and characteristics of health care facilities, the population to be served, roads, and, in some instances, such items as railroads and military installations (training grounds).

2. Patient as Priority. Clearly, the staff of the clinic sees the patient as its top priority. Accordingly, staff members focus their attention on ensuring patient satisfaction.

3. Patient Satisfaction Survey. Patient satisfaction surveys are used in a modern sense. They indicate a high level of satisfaction and suggest that patients are willing to refer friends and family members to the practice.

4. Health Indicators and Impact. Basic tracking demonstrated that the average length of stay has decreased and that immunization levels have increased. Both measures are better than the city hospital and exceed those for the oblast. The director of the group practice points to earlier prenatal care, fewer late-stage cancer diagnoses, fewer advanced TB cases, and a one-third reduction in hospital admissions. Moreover, the number of referrals declined; and, with extended evening and weekend hours, the rayon had no ambulance calls.

5. Improved Access. Extended hours, weekend hours, and home visits have been important factors in patient satisfaction. The six family practitioners see one and one-half more patients now than before and make twice as many home visits but express greater satisfaction in working in this setting.

6. Team Concept of Care. The team approach has strengthened the practice by linking doctors and nurses in delivering care to the same patient. Moreover, the team concept has clarified the role of the nurse and given nurses greater confidence in performing their tasks.

7. Clinical Pathways. Using the top 20 diagnoses to identify priorities of clinical pathway design, the group practice developed pathways for such high-volume disorders such as pneumonia, chronic tonsillitis, chronic otitis, and varicose veins. Four clinical paths have been developed for each department. In the case of the acute pneumonia pathway, the implementation resulted in a decrease of the average length of stay from 23 days to 14, a source of both pride and encouragement to further achievements. Prekazy (detailed policies and procedures for clinical management—a holdover from Soviet medicine) do exist, but the efforts in Lviv offer an opportunity to reset the norms. In addition, the clinical pathways have provided doctors with an educational tool for nurses, thereby solidifying the concept of team care.

8. Finances and Budgeting. Before ZdravReform, FM #1 had begun to work on improved budget allocations. With ZdravReform's support through computerization and Excel training, the clinic staff has been able to implement financial tracking down to the provider level, incentive systems, self-financing, and user fees. Through the comparison of department costs and revenues, FM #1 has decreased the surgery department's average length of stay. The clinic staff has held seminars on user fees, with 16 departments

now categorized with user fees. FM #1 is also able to track the percentage from the public budget for user fees and whether FM #1 providers were reimbursed.

9. Provider Incentives. Because of the financial tracking system, the group practice has been able to monitor the volume and type of services (degree of complexity of visit) delivered by each provider. The data are used to generate information that becomes the basis for incentive pay.

10. Collaboration. Because the group practice has developed collaborative relationships with polyclinics and hospitals with respect to the inpatients from FM #1, it is able to exert more control over the use of inpatient services. (Compare this arrangement with that in the Central Asian Republics, where the strategy calls for breaking away from polyclinics.)

11. Specialist Rotation. One innovation introduced by the group practice was the clinical rotation (periodic reassignment of clinical staff) of resident specialty care physicians through the hospital and polyclinic in place of a permanent assignment in one place or the other. The impact was noteworthy for greater continuity of care and better use of inpatient services. The specialty care physician often knew the patient from an ambulatory standpoint and expedited the hospitalization and services therein.

12. Role of Home Visits. Although some providers have identified home visits as less efficient than office visits, none expressed a desire to discontinue them. (Providers see 12 to 16 patients in a half day at the office as opposed to five to seven in home visits in an afternoon or evening.) The doctors' willingness to make house visits may be due in part to the perception that such activity leads to fewer hospitalizations and higher patient satisfaction.

Zhovkva Rayon Health Complex. While the evaluation team did not visit the health complex (staff at the facility were not available), it did interview the head of the rayon hospital. Responsible for the conversion of facilities into outpatient centers, the hospital's head has facilitated the closure of 29 percent of the rayon beds and the consolidation of two major departments. While local authority strongly resisted these difficult management decisions, the impact has been significant. Once the rayon health administration ascertained that the budget allocation method had changed from a bed-day to a per capita basis effective January 1996, it focused on the necessary reduction and consolidation. As a result of these difficult management steps, the hospital has been able to reallocate resources from the converted facilities to the new ambulatory clinics and the purchase of drugs and supplies. Unlike other rayons that had already spent their entire annual budget as of October 1996, Zhovkva had spent only 70 percent of its budget. It has paid all salaries and will close out the year doing so.

The underdevelopment of community social care functions and the lack of drugs have meant that many patients have declined hospitalization. As a result, the rayon has seen an exodus to the outpatient centers. Per capita budgets have been calculated and allocated, but payments between and within facilities have not occurred.

The rayon took the initiative in mid-July 1996 to conduct a roundtable on user fees. All 36 head physicians in the area participated in the forum, indicating a forward-thinking attitude on the part of the local administration and a sense of reality as budget constraints require decision makers to make more rational use of funds. Existing budget gaps, problems in purchasing drugs, and limited diagnostic and laboratory equipment are among the issues driving change.

Within Zhovkva rayon, a predominantly rural area of 111,000 people, the sense is that the assistance of ZdravReform was critical to the above achievements. ZdravReform has served as both an educator and a mediator, especially vis à vis the local authorities in the case of the issues associated with restructuring. With the collaboration of ZdravReform and the rayon, the rayon governor granted the rayon state administrator deputy and the head of the rayon hospital the authority to close down unnecessary facilities despite the constitution's Article 49 prohibition against such an activity. This action provides an example of a first step toward restructuring health facilities. The next steps will address medical insurance, cost finding and pricing, and the development and implementation of clinical pathways similar to those at FM #1.

Department of Surgery, Polyclinic #2. The Department of Surgery at Polyclinic #2 provides a different model of health care delivery in Lviv. Unlike the institutions and activities already discussed, this clinic is part of a polyclinic and largely focuses on incentive payment activities. It is composed of a group of surgeons who want to form a private company on a six-month experimental basis. The surgical group would continue to care for patients for free but could charge user fees for some procedures. Half of the fee amounts collected during the experiment would be allocated to the clinic for the purchase of equipment or facility improvements. The group would retain the other 50 percent for performance incentive pay or improvements to the surgical practice. At the time of the evaluation team's visit, the city health administrator had just given oral approval to the concept.

Dneprodzerzhinsk Family Medicine Clinic. Although not part of the IDS strategy, the integration of medical insurance, private practice, and family medicine that has occurred in Dneprodzerzhinsk is worthy of mention. It demonstrates some components of an HMO and the need to balance feasibility against reality. Time constraints prevented the evaluation team from visiting the site, but the medical director agreed to come to Kyiv for interviews.

The Polyclinic of Family Medicine (PFM) was founded in 1989 and is an early example of a health care delivery system that was started without state funding and that has attempted to function under its own health insurance plan for ambulatory services. With 27 physicians (63 employees total), it has grown to 15,000 members, in large part due to its willingness to

experiment with some of the innovations suggested for health care reform. For that reason, it merits consideration as a potential IDS.

Commitment to the following principles is another reason that the PFM may be worthy of a case study: customer orientation, continuous operation, commitment to the truth, staffing by neighborhood physicians and nurses, scientifically based practice with a receptivity to new technologies and an expanded range of services, and performance-based pay. Moreover, the clinic's philosophy that a doctor is the primary provider of care is consonant with the concept of family medicine as actively promoted by ZdravReform in the IDS. In addition, better health outcomes and more efficient care are the results of PFM's clinical and management team efforts.

The PFM plan has seen notable reductions in mortality rates, emergency ambulance usage rates, hospitalization, and referral to specialists as well as higher prenatal care and birth rates and the realization of substantial savings due to managerial efficiencies and higher-quality clinical services. Given that the PFM's successes are independent of major state support, the Mission, through ZdravReform, may want to suggest to oblast officials in Dnepropetrovsk and to national officials that this model be rolled out to other oblasts under ZdravReform.

Railroad Health Insurance Experiment. This controversial initiative, although endorsed by the Cabinet of Ministers, reflects the self-serving nature of the National Railroad Administration and those likely to benefit from insurance revenue. Interviews with key players suggest that the experiment pays insufficient attention to the principles of health care reform. The adverse risk selection of the users of the health care system, the lack of replicability to a broader population, and the importance of fund generation over efficiency all indicate that the experiment is not likely to be relevant to the goals and objectives of either ZdravReform or USAID. Some ZdravReform staff are willing to provide technical support to the experiment, although they simultaneously express concern that the experiment may spin out of control and that hidden agendas may supersede real health care reform initiatives.

Patient Surveys. A Lviv patient survey compared two models of family medicine: the family medicine ambulatory (FMA) model and the family medicine department (FMD) model. The FMA is a freestanding facility; the FMD is a department established within the framework of an existing medical facility. The survey had four goals: to evaluate the level of patient satisfaction with family physician care; to compare the current treatment patterns of different family medical models; to solicit recommendations from patients; and to ascertain patient attitudes toward an incentive payment system. Armed with 27 questions, the research team interviewed 450 patients at either the FMA or the FMD. Over two-thirds were adult females. The results favored the freestanding unit and strongly supported the IDS concept of family practice groups. In general, patients perceived service at the FMA as better and more efficient. In addition, referral rates were lower, the frequency of calls for ambulances was lower, and loyalty was greater to the FMA practice model. The survey was statistically significant but was targeted. The sample was limited to those patients who patronized the centers while several questions solicited subjective responses.

ZdravReform supported a national survey in fall 1996 on public attitudes toward health care reform. While the data had yet to be analyzed at the time of the evaluation team's visit, survey activity builds the capacity of local survey research firms and the MOH.

4. Partnerships with Other Agencies

Partnerships with other agencies may strengthen or complement the present and future activities of ZdravReform and the IDSs. Beyond the partnership with the University of Colorado and the Nadiya Group, USAID should identify other groups willing to carry on didactic as well as bedside teaching through RFPs, especially as clinical activities and the demand for family medicine training increase. As interest in family planning counseling and techniques grows, collaborative efforts with the USAID Reproductive Health Program and the United Nations Development Programme (UNDP) would be appropriate. The AIHA partnership program, well funded by USAID's earmarks for international hospital-to-hospital exchanges, has been mentioned as another possible collaborator; however, a local assessment holds that the AIHA program is highly hospital-oriented and has led to redundancies of high-tech units within hospitals in single catchment areas. It would also seem that such a program is focused on neither ambulatory care and family medicine nor fundamental health care reform and restructuring of services.

5. Information Systems

Ukrainian staff recognize the growing need for systems that can generate information on utilization, costs, revenues, quality, and outcomes as a condition of making operational decisions within the framework of reform. Moreover, such information systems support quality assurance and identification of areas where the principles of quality improvement can be applied. Many components besides the hardware must be in place for such a system to serve its intended purposes: trained staff, appropriately adapted software, forms for collection of data, and, of course, sound data. With respect to the last, informed data collectors are essential, especially given Ukraine's legacy of voluminous data collection without a vision as to the information's conversion into useful data. Future thinking about data storage capacity and the computing power of the hardware must also be reflected in information systems planning.

The main activity in Ukraine, beyond planned installation of hardware and training at Lviv, was an evaluation of the Dnepropetrovsk information systems (MEDECA), which, earlier in 1996, involved City Hospital #16 and the hospital at Nikopol Polyclinic. The evaluation revealed a high interest level and skill base; but, without national guidance, a multiplicity of incompatible systems would likely emerge. Moreover, the evaluation team developed the sense that the developers of systems and the end users of the products were not necessarily communicating with one another about data needs for linking services to costs to clinical management. Lack of data standards, lack of unique patient identifiers, and lack of data comparability are all barriers to the functionality and intercommunication of systems. The policy vacuum may not be one that ZdravReform can address; with leadership and strategic planning, however, the information systems could potentially be cost-effective. The systems may be beyond the ZdravReform mandate but could nonetheless facilitate the establishment

of data requirements to meet user needs, as suggested in the previous information systems evaluation report (Coburn), through the IDS projects now underway. In addition, the Ukraine IDSs may benefit from exchange with the Kazakstan and Kyrgyz Republic information systems staff.

In the fourth quarter of 1996, new 486-level computers will be installed at each family medicine clinic, Polyclinic #2, and the hospital. They will be linked to form an information network for patient referral and interfacility communication, thereby allowing financial, managerial, and clinical reporting and trends analysis, which are planned for the ZdravReform installation and training courses.

6. Quality Assurance (QA)

City Hospital #2 embodies the basic elements of QA. The staff track health indicators, such as immunizations, prenatal care encounters, stages of cancer diagnoses, TB incident cases, clinic admissions, referral rates, ambulance usage rates, and extent of access. Benchmarking these indicators against the performance of other parts of the oblast shows that the hospital's performances are best practices. The development of key clinical pathways and their application to high-volume diagnoses has led to decreases in the average length of stay, greater continuity of care for patients, and higher levels of patient satisfaction. The clinical pathways also serve as an educational tool. Tracking clinical services and linking them with costs has allowed staff to conduct provider profiling with feedback to physicians as to whether they are performing within the clinic's standards and expectations. Such self-corrective courses contribute to lowered costs for the group practice; in fact, City Hospital #2 has managed to operate within budget this year. Team concepts of care are applied with the result that patients refer their friends and family to the clinic and are reluctant to change providers. Home visits, although viewed by physicians as costly in terms of time, result in fewer clinic visits, more manageable health conditions, and greater patient satisfaction. Staff pride in the physical facility is evident in the form of fresh paint on the interior and exterior walls, flowers around the building, and the welcoming surroundings for patients while they wait to be seen.

7. Oblast- and Rayon-Level Dynamics and Constraints

Interviews with local health authorities in Lviv indicated full support and appreciation of the ZdravReform program. The deputy oblast health administrator (Dr. Nadiya Melnick) remarked that although the oblast had received orders and permission to proceed with health care reform, it was ZdravReform's practical and essential assistance that made the difference. In addition, ZdravReform was perceived as fully supporting the oblast—through the design, foundation laying, and implementation stages. When the oblast received only 18 percent of its expected budget, reality struck; with ZdravReform, however, the oblast health department (OHD) was able to push for more reforms, including user fees. The OHD's actions are noteworthy given the Article 49 prohibition against user fees, although the OHD specified the services exempt from such fees. The OHD is aware that taxation methods (and informal payments to providers by patients) will have to change once user fees are fully implemented and thus plans to cover variable costs with user fees. The head of the OHD spoke favorably

about the restructuring activities in Zhovkva, the innovations in family practice medicine at Lviv City Hospital #1, and the privatization strategies within Polyclinic #2. She foresaw the ongoing need for exchange programs with facilities in the United States, Great Britain, and Canada.

The Lviv city health administrator (Huzar) viewed the efforts of City Hospital #1 and Polyclinic #2 as far ahead of the city decrees for health care reform. In adapting to financial constraints and budgets, the institutions have looked for and found new managerial and economic methods such as cost-effective family medicine, selective reduction of the workforce, and the imposition of user fees. The health administrator viewed the practice of family medicine as a good approach that allowed for continuity of care. He suggested the replication of the two successful practices elsewhere in the city and said that ZdravReform is potentially instrumental in guiding reductions in the workforce and the rationalization of facilities. He also saw user fees as a means of reducing or even eliminating informal payments, with performance-based salaries as perhaps the next step. The health administrator assigns top priority to alternative sources of funding as a topic for collaboration between the city and ZdravReform.

C. Conclusions

1. Project Design and Project Targets

The ZdravReform Ukraine project was designed to introduce market reforms in the health care sector and to improve efficiency, quality, and access within existing systems. The Odessa IDS focused on the first strategy and the Lviv IDS on the second. In its focus on the development of family group practices, the Lviv IDS demonstrates the success of privatization, the power of participation by individuals in decision making, innovative clinical practices that acknowledge economic realities along with political agendas for change, and the practical means to address the primary health care needs of the population. The IDS project targets have been directed at priority needs. The targets reflect the leadership transition within the Ministry of Health and the redefined vision for the country as expressed in the new constitution. Evidence not only shows that the experiments in health care delivery are sustainable but also points to eagerness to replicate these successes in other rayons and oblasts. Additional evidence suggests the creation of some synergies. Further, one NIS country has shared information to a limited extent with the others. Project targets are attainable in light of present realities as long as the momentum for change is not thwarted by further instabilities or a loss of vision in the case of a change in central leadership.

2. Implementation and Delivery Modes

Some impediments to progress have dissolved with the establishment of a MOH that has endured longer than its predecessors. Some reform objectives have been advanced, including the establishment of family medicine as the primary delivery mode, the primacy of alternative payment mechanisms, and the need for legislative measures to ensure that the rationalization of health care facilities is carried out judiciously and within consensus-derived standards in licensing and accreditation.

Counterparts have welcomed the proactive role assumed by ZdravReform within legislative circles, within boards and committees involved in medical curricular changes, and within the administrative structure at the rayon, oblast, and central levels. ZdravReform's involvement has resulted in the formulation of documents, decrees, and policies in support of national agendas. Moreover, ZdravReform activities testify to the successful interface and engagement of the contractor with local counterparts; indeed, observations lend support to the prediction that some counterparts will be ready to assume a larger leadership role as the project matures. The output of the IDSs demonstrates the effectiveness of the structure, management, and operational principles of ZdravReform. Nonetheless, the lack of national-level information systems guidelines may hamper the implementation of information systems that can link local financial and health data as well as interface with regional centers of care. Although information systems policy development does not seem to be a present priority, it is unavoidable and will only become more complex if ignored at this early stage.

3. Achievements and Impact Potential

Given the success of the IDSs and the growing interest of other rayons to be part of the roll-out plans, project targets are likely to be met by the end of the contract. Many of the clinical and administrative achievements of the family practice groups offer potential for replication; they are limited only by the degree of readiness of the recipient district, the local health administration's receptivity to innovation, and the availability of ZdravReform staff to facilitate family practice implementation. Moreover, the increasing involvement of outside collaborators in family practice training has been effective and well received. Yet, the need for training will grow. Project staff should seek more collaborators who are either independently funded or willing to volunteer assistance. It will be important for local counterparts and the National Board of Family Medicine to be involved in planning for training, decisions about equitable distribution of assistance in training and equipment support, and planning for competency-based certification of trainees. Because clinical training is outside the scope of expertise of the present contractor, Abt should envision its role as facilitator rather than as a direct implementor of educational goals. As a result, the contract should not require major additional funds.

4. Refinements and Modifications

A key lesson is the value of working at both the local and central levels such that an ongoing exchange of information avoids the rejection of new ideas developed only at one level and instead leads to consensus building at early stages. Two cases in point are the activities associated with licensing and accreditation and medical curriculum development. In both instances, decision makers are involved at the city, oblast, and MOH levels as well as at the legislative or academic levels. A second lesson is the value added by outside collaborators, such as those volunteering to assume roles outside but complementary to the contractor's mandate. The example is in the role played by a U.S. university in the clinical training of family practitioners. Another potential collaborator is the School of Public Health Administration and its potential for supplying staff for roll-out sites, whereby both the site and the newly trained staff would benefit from the marriage of reality and theory.

Two areas that need to be addressed to promote market reform are information systems (for both health and financial data) and communications and marketing tools. Information systems would provide significant advances in quality assurance, quality improvement, and utilization management. Communication and marketing tools would publicize the benefits of health care reform as well as allow a forum for feedback. More cross-fertilization between NIS countries would be beneficial while the marketing of successes would accelerate the acceptance of change.

IV. MANAGEMENT

The Regional Mission for West NIS (USAID/Kyiv) has grown rapidly over the past several years; the original staff of 30 expanded to 150 in 1996. As a result, the Mission has been able to advise, monitor, and develop the programs implemented by contractors. The Mission's target close-out date is 2002, one of the latest close-out dates for the Bureau for Europe and New Independent States (ENI) region. For the meantime, the Mission remains committed to supporting health care reform activities.

The Mission's original emphasis on privatization has expanded to include improving the social sector and the health care system as a vital parallel activity. Health care financing and service delivery reform is included in the Mission's R4 under strategic objective 3.2: "to improve the sustainability of social sector benefits and services." Nonetheless, the Mission has experienced some frustration with Congress's "earmarking" of annual budget funds for USAID/Kyiv to certain health programs, most notably the Medical Partnerships program and the Women's Reproductive Health Services Expansion Program. The "earmarking" limits the Mission's flexibility and support for other health and social sector programs. The Mission recognizes, however, the fundamental linkage between economic restructuring and reform of the social benefit structure, which supports employers, employees, and vulnerable populations. The Mission also understands that a viable, visible social safety net enhances public support for future reforms and thus complements economic and political restructuring. Despite limited resources for the health portfolio, the Mission supports continued health care system reform activities and is considering a one-year extension of the ZdravReform Program for 1997.

The USAID/Kyiv project officer outlined the Mission's priorities and efforts to integrate health care reform more fully into strategies directed at decentralization and the shift to a market orientation. Recent visits by Mission Director Gregory Huger to ZdravReform pilots in Lviv and Odessa have helped emphasize the important role of health care reform in the broader assistance strategy. Huger's visits also had the effect of promoting the program to the Ukrainian press, among Ukrainian leaders, and within the Mission.

The USAID/Kyiv project officer outlined some management and technical issues and concerns, the resolution of which will determine continuation of the ZdravReform program in Ukraine. These issues and concerns are noted below.

- C The Mission and contract staffs need to coordinate policy advice to the government of Ukraine and the Ministry of Health on reform and restructuring issues in order to avoid sending a mixed message.
- C ZdravReform's intensive demonstration sites in Lviv and Odessa have demonstrated several important health care financing and service delivery models in pilot facilities. The program is now at a critical juncture whereby models should be rolled out to other sites; new or missing components should be introduced; and lessons learned and model results should be communicated to the regional and national levels to promote policy change.
- C Since the May 1996 departure of Dr. Marc Stone, the ZdravReform program in Ukraine has lacked a full-time country director (chief of party). After Dr. Stone's departure, there was a question about the continuation of the Abt contract and the continuity of the program. This was resolved by the summer 1996 decision to extend the project and the contract subject to Abt identifying and hiring a qualified team leader. The dual rotating leadership plan approved by Abt/Bethesda and USAID had been adequate as an interim arrangement. It has facilitated the production of a substantial amount of good technical work. It does not, however, respond to all the requirements that would be satisfied by a full-time team leader in place and running the day-to-day operations of the Ukraine program.

While the Abt/Kyiv office has not been fully staffed, the IDS offices in Lviv and Odessa remain fully staffed. At the request of USAID, Abt Associates is currently recruiting for a full-time country director. As of late September 1996, Abt has submitted the names of four candidates to USAID. In addition to identifying the Abt/Kyiv staffing problem, Abt noted the following management issues:

- C Uncertainty surrounding the 1997 extension for Ukraine has impeded ZdravReform's ability to plan new activities.
- C The program should devote more attention to the recruitment and nurturing of local professional staff who can manage offices and promote the reform package once ZdravReform ends.
- C The program should ensure a productive working relationship between the country director and USAID/Kyiv.

In conclusion, USAID and ZdravReform will continue planning new activities. Yet, several issues remain—whether to continue the original design with the greatest share of resources and effort focused on the intensive demonstration sites, whether new demonstration sites should be identified during the next year, and to what degree work at the national level should be intensified.

V. PROGRAM DESIGN

After two years of activity, the ZdravReform program has developed a set of useful health care reform models that have been field tested in Lviv and Odessa. The project has also worked at the national level to encourage health care reform policy, but it is at the oblast and municipal levels where the clearest results have emerged. Given the findings in sections II and III of this annex, it is clear that the models developed to test new financing methods, including various incentive payment concepts, new organization of service delivery concepts, and management information systems, are relevant to the current economic and social situation in Ukraine.

The economy of Ukraine has suffered steep declines in output and real economic activity during 1994 and 1995. Real GDP fell by approximately 23 percent in 1994 and 12 percent in 1995. Real wages, real expenditures, and gross investment all experienced similar declines. Likewise, both industrial production and agricultural output fell significantly. To counter these trends, the government is following stringent macroeconomic policies and is instituting substantial structural reform to move to a market economy. This downward trend, however, is part of a longer-term decline that has seen millions of Ukrainian families slide into poverty since the collapse of the Soviet Union.

Since it appears likely that a number of years will elapse before the economy bottoms out and begins to grow at a reasonable rate, Ukraine will have little opportunity to increase public financing for the state-managed health care system. Therefore, it is important to build and expand on the systems supported under the ZdravReform program in Lviv and Odessa to meet at least part of the demand for quality service. New funds flowing into the health care system from user fees and from savings that accrue from more efficient organization can be used to ameliorate the current underfunding of the health care sector.

Many national- and some local-level officials suggest that a national health insurance system is needed to fund health care adequately. Officials almost always describe the system in terms of a payroll tax levied on firms. But since a preponderance of firms are public sector firms and are not paying their bills, it is hard to see where the additional money would come from for a national health insurance system. In addition, current speculation holds that the already high tax on firms for social insurance requirements will be cut in the near future to meet the national government's economic restructuring targets.

One could make the case that the model systems developed in Lviv and Odessa offer the government a chance to address at least some of the financing problems in the health care sector by applying the savings from increased efficiencies and the new funds from fees for service. When the economy begins to grow again, additional options for both public and private financing will emerge. The government, however, cannot wait until a future date to take action. It needs to look at its options today and select from among those that offer the best chance to improve health care delivery over the short run.

In this environment, the project should continue to refine the models developed in the IDSs. It should test them in new geographic regions under different socioeconomic conditions. It should look for new models that would support the short- to medium-term needs of Ukraine in meeting its health care needs while continuing the information campaign about successful

local programs, particularly the education programs that are introducing new ideas into the health care sector.

At the same time, the project should lay out an action plan to operationalize the vision contained in the paper entitled “Directions for Health Reform Strategy Development in Ukraine” (see Annex J). The paper lays out a program that calls for policy makers to move away from a focus on resource generation and toward a concentration on the allocation of resources to providers for payment reform. An important complement to new payment methods would be to grant autonomy in management and operational financing and to provide consumers with choice and information. This would motivate the provider system to become more efficient and responsive to consumers while maintaining access and improving quality care.

The debate over alternatives to the general government budget as a source of funding will continue but should be broadened to consider options beyond the payroll tax. Such a change of focus means moving away from government as the dominant player to shared authority among levels of government, consumers, providers, and, possibly, employers.

Next Steps

Abt has provided sound management of the oblast-level activity. It has also provided significant input into the policy dialogue on health care issues in Ukraine while the Mission succeeded in elevating the health care dialogue within the context of its overall policy dialogue with the government of Ukraine. To a large degree, the Mission’s success has resulted from the interaction of the Mission, the Abt contract staff, and the Ukrainian officials at work on the model programs. Indeed, the team observed a high degree of interaction between the Mission and the contract team relative to project actions and issues. That interaction is a strong component of overall project management. The project officer has demonstrated a sound understanding of the project, down to the finest detail. She interacts with the contract team on a regular basis, visits the project sites, and shows a level of concern for the substance of the project. The Mission director recently visited both oblasts and met with most of the major counterparts who are working on the reform models. Oblast officials made numerous comments about these visits, which clearly sent a strong message to those involved in the health care reform effort.

This is a good example of how good contract project management and strong mission project management have advanced the strategic objective of the U.S. government. The visible interest of senior Mission management in the oblast demonstration sites has given the imprimatur of the U.S. government to the health care reform effort. This is an important political signal in a political environment where senior national-level officials are still somewhat ambivalent toward the necessary structural change that must occur if the health care system is to operate efficiently and effectively in an open economic system.

As was the case in Central Asia and Russia, the time line for the ZdravReform program in Ukraine was not realistic. Reform of the health care system is a long-term process. Overcoming political, economic, and social inertia takes time. The IDS project implementation model is an ideal approach that has allowed for experimentation at an

operational level. It has begun to produce model systems that can be replicated and retested in different environments. In fact, if a breakthrough can be made at the national level, Ukrainian-tested models of health care reform will stand ready for consideration as part of a national program.

The Mission and the contractor are at a critical point in the life of the project. The first round of oblast tests is nearing completion. The results have been promising. One senior national-level Ukrainian official noted to the evaluation team, “We have learned as much from the tests that have not gone well as we have from those that have succeeded.” His implication was that the process was an important step for Ukraine.

The next phase of the project is ready to go forward. In its plan document entitled “Directions for Health Reform Strategy Development in Ukraine,” the Abt team has already laid out a vision for the necessary next steps. The Mission and the Abt team need to specify the operational steps needed to turn the plan into an input/output model. The next steps in health reform in Ukraine will be critical.

The Mission brings to the team an understanding of overall U.S. government goals and objectives. The Mission has a deeper insight into the U.S. government’s progress in its negotiations with international lending institutions. These broader negotiations will undoubtedly shape the options available to the Ukrainians as they begin to reform health care. The Abt team, of course, brings to the team its considerable knowledge of the Ukrainian health care system as it currently functions and a sensitivity to what is feasible. Properly structured, a team approach to defining and implementing the next phase of health care reform could be a win/win situation for the Mission, Abt, and, most important, the Ukrainian people.

VI. RECOMMENDATIONS

A. Project Design

1. The Abt contract should be funded for the final two years of the project. The Mission and the Abt field staff should cooperatively plan the final two years of the program.
2. The program should continue to work at the oblast level. It should further refine the models developed to date and test them in new geographic regions. At the same time, it should intensify the work at the national level on overarching policy issues and the legislative framework needed to underpin a national health care system.
3. The Mission should continue to keep health care reform a top priority issue in its national policy dialogue. It should seek to integrate broader economic transition and health care reform issues and continue to emphasize the linkages between overall economic transition and a viable health care system.
4. As part of defining the program over the next two years, the Mission and the contractor need to decide how to handle the apparent disconnect between Article 49 of the new

constitution, which constrains the use of fees for service in the health care system, and the project-supported local initiatives that use fees for service as a principal tool in the health care reform models being tested.

B. Management

1. The locus of project management should shift from Washington to Kyiv. The present arrangement evolved before the Mission in Kyiv was fully staffed. The ENI Bureau should seek ways to shift the management function in accordance with reengineered concepts and tools.

2. Abt and USAID need to move quickly to fill the team leader position in Kyiv.

3. The Mission needs to coordinate the various projects and programs in the health care sector to ensure that they are as mutually supportive as possible. For example, potential exists for collaboration between the reproductive health program and the clinical interventions under the ZdravReform program. At the least, the Mission should discourage programs from working at cross-purposes.

4. USAID and Abt need to act as a catalyst to ensure that the experience gained at any particular site is shared as widely as possible throughout the NIS. The evaluation team saw numerous situations where progress at one site was directly relevant to ongoing work at another. More needs to be done to share the project's valuable work.

5. The Mission and the contractor need to continue to support the project's information dissemination and public affairs activities. Creating an awareness of and developing education programs about the health care models used in the tests will help promote primary care and could help reduce the demand for more expensive specialty care.

C. Implementation Approaches

1. Abt should consider the use of an itinerant resident adviser to facilitate the rapid roll out of the facility-based reforms, although the budget might place a cap on internal transport and temporary housing costs.

2. Assessments of support staff and the rapid deployment of that staff either as clerical staff or financial assistants will be critical in settings where the learning curve is steep. Personnel and providers who have the vision but not the practical skills for reform may become overwhelmed and burn out without team-based staff support.

3. The training of future policy makers is pivotal to the sustainability of present activities and essential to the reproducibility of IDS efforts in other oblasts and rayons. Graduates of the School of Public Health Administration in Kyiv and the Medical University in Odessa could be appropriate resources at the oblast level, particularly in areas where ZdravReform expands its activities. Such personnel would serve as a useful support to startup projects as well as provide field experience for a new cadre of health care managers.

4. Practical management courses (workshops, seminars) in the form of just-in-time training should be planned to coincide with roll out. Training will be needed in such topics as team building, conflict negotiation, hiring and firing, managing provider performance, office staff supervision, and setting of realistic performance standards. In addition, courses in time management, task delegation, and strategic planning would be appropriate.

5. The project should promote the licensing and accreditation of health care providers, thereby permitting consumers to determine the qualifications of their health care providers, creating a demand for continuing medical education, and providing a means for potentially reducing the number of health care providers in the country.

6. If reform policies enable implementation of an insurance system, the project should continue exploring the insurance option as a long-term health care financing solution.

D. Clinical Issues

1. As the clinical program expands, the University of Colorado Family Practice Group may not be able to meet the increasing demand for retooling local practitioners. A new arrangement will be needed. A two-pronged approach that relies on both short-term family practice residents from U.S. programs and long-term faculty (one-year minimum) would ensure continuity and a deeper understanding of both training needs and the pace of new skills acquisition.

2. Before the training activities accelerate, the source of technical assistance to the training program should institute a plan for teaching the methodology of instruction. Training of trainers should not be limited to course content but rather should also include techniques on adult learning styles, group dynamics, presentation styles by instructors, development and use of audio-visual materials, course competency testing, and early identification of learning barriers.

3. The project should discourage donations of drugs to small clinics (University of Colorado experience).

4. The project should selectively invite counterparts to participate in U.S. study tours and clearly define trip objectives and the expected application of lessons once participants return to Ukraine.

5. The project should ensure that family medical groups have a minimum of two practitioners to allow for cross-coverage of patient care, flexibility of office hours, and mutual professional support. Eventually, each practice should, depending on its size, consider having a practice manager to track accounting and utilization management by providers in the group.

6. The project should require clinical training to be complemented by instruction in patient-focused care. Such training is an integral component of reform. Once competition in the health care sector becomes more apparent in the market economy, patient perception of competence will be a major factor in patient satisfaction with the overall health care system.

7. The project should consider using the services of a local survey-experienced group to conduct periodic patient satisfaction surveys. Surveys allow for quick assessments of and course corrections to experimental models of health care service delivery.

8. The project should consider educational tools in the form of CD-ROMs, as already suggested by the University of Colorado. ZdravReform should address related technological and logistical needs. For easy access, hardware and software should be housed at either the ZdravReform offices or an IDS facility.

9. The project should ensure the availability of basic equipment such as otoscopes and ophthalmoscopes, eye charts, growth charts (National Center for Health Statistics [NCHS] standards), basic diagnostic laboratory tools (dip sticks), and glucometers. Patient education sheets in Ukrainian would be helpful, as is planned by the University of Colorado.

10. The project should strengthen the role of the primary care nurse. Given the present shortage of family doctors and the availability of nurses, a refresher training course may extend the utility of the doctor at family medicine clinics. The project should also explore the role of primary care nurses with the Department of Nursing at Lviv Medical University.

11. Upgrade medical record keeping by using the SOAP (subjective, objective, assessment, and plan) method, problem lists, immunization sheets, medication logs, and patient and family history sheets. The overall organization chart suggested by UCO is ideal but may be ambitious or prohibitive because of printing costs. Nevertheless, some principles of organization could be applied.

E. Information Systems and Communication Strategies

1. The project should facilitate the development of data requirements for information systems. Specifically, data sets will link financial data already being collected on paper with patient and service utilization data to provide facilities (in IDSs) with useful data to assess the quality of health care services. The evaluation noted that ZdravReform plans to install an MIS among certain facilities in Lviv for patient referrals and interfacility communication, once computers are available. The Ukraine IDSs may benefit from exchange with the Kazakstan and Kyrgyz Republic information systems staff, as the latter have developed and are operationalizing integrated payment and service utilization data systems that will track costs, facility and provider performance, and eventually health outcomes within entire oblasts.

2. While the team notes that the majority of ZdravReform computers were not in place at the time of the team's visit, it recommends that adequate follow-on support and training (as well as equipment) be given to the IDS recipients.

3. The project should seek out some expertise for assistance in report writing to allow for more concise reports with clearer statistical analysis. Reports tend to be more descriptive than analytic.

4. The project should develop a marketing strategy to accelerate changes and their acceptance.

5. The project should distribute software developed by Abt consultants to more providers to help them in both determining costs and charges and developing departmental budgeting techniques. The software will allow local staff to estimate the cost of retaining the present system versus the cost of options identified by the health care reform effort. In addition to the cost-accounting software, the Russian project has modified the patient tracking “Arena” software, which may be of use to Ukrainian counterparts.

F. Quality Assurance

1. The project should support the pilot implementation of QA programs in hospitals in Lviv, Odessa, and a third oblast. Many successful examples can be derived from City Hospital #1 FGP.

2. The project should define key quality indicators as a prelude to monitoring and standardizing them for all facilities within the expanded pilot (roll out). City Hospital #1, which has already tracked some health impact indicators for comparison with nonintervention facilities, should be used as the example.

3. The project should rank order the diagnoses of ambulatory and inpatient cases as a means of focusing on essential clinical pathways and tie these pathways to either process or outcome measures to track whether the pathways are followed and are influencing provider care.

4. The project should use the financial tracking system to develop provider profiles to allow for feedback of utilization of resources.

5. The project should determine whether physicians might be interested in studying the cost-effectiveness of home visits (provider time, patient satisfaction), perhaps by investigating an expanded role for visiting nurses. As practices grow, providers may be more inclined or required by circumstances to spend time with patients in the office rather than traveling to homes.

G. Utilization Management

1. The project should collaborate with the University of Colorado to develop conversion protocols for the reconfiguration of hospitals to day-stay and social care facilities, which should be staffed with family practitioners and trained paramedical personnel. ZdravReform staff can provide advice on how to respect the constitutional prohibition of closing down facilities while rationalizing them as indicated by actual data and local needs.

2. In conjunction with clinical pathway development, the project should establish admission and discharge criteria applicable to hospitals.

3. The project should take the necessary next steps to define alternative sources of financing such as user fees and the private medical model of self-financing as exemplified in the Polyclinic #2 Department of Surgery in Lviv. Theoretical models, as opposed to actual experiments, will not carry the weight needed to convince local authorities that alternative financing is viable.

ANNEX D

RUSSIA

I. OVERVIEW

A. Background

Over the past ten years, Russia (formerly the Russian Republic of the USSR; now the Russian Federation) has experienced varying success in experimenting with reform of its health care system. On the one hand, Russia's health care system provides advanced specialty and tertiary services and can point to a sophisticated, educated workforce. On the other hand, however, it is plagued by outmoded, inefficient resource allocations, technology, and practices. Under the New Economic Mechanism (NEM) of the late 1980s and early 1990s and, more recently, with the 1991 Russian Law of Mandatory Health Insurance, Russia has attempted to address the systemic inefficiencies and poor health outcomes associated with a "command economy"-driven health care system. Under the NEM, pilot sites in Central Russia (Kaluga) and Samara and in Siberia (Kemerovo, Altai Krai) have experimented with new organizations (Territorial Medical Organizations) for local-level payment and oversight. The goal was to expand family practice, establish full-fundholding reimbursement (putting family practitioners at risk for total patient care), create provider incentive and bonus programs, and initiate some quality assurance activities. These early experiments have provided a beneficial working experience for health care leaders in the regions. These same leaders later worked with ZdravReform on new payment and quality assurance mechanisms.

After dissolution of the Soviet Union, the Russian Federation passed the 1991 Law on Mandatory Health Insurance. The law took effect in 1993² and created a special nonprofit body, the Mandatory Health Insurance Fund (MHIF), with regional branches (at the oblast level) to serve as a repository for contributions collected from employers for the working populations and from local health care budgets for the nonworking population. The MHIF at the oblast level, in conjunction with regional health and state authorities, is responsible for collecting a 3.6 percent tax from local employers to pay for their employees' health insurance. This tax was not a new tax but rather a redistribution of existing employer contributions for social insurance. The oblast-level MHIF contracts with private health insurance companies that compete among themselves to provide mandatory health benefits and, optionally, voluntary insurance that provides additional benefits above and beyond the mandatory package of services. The nonworking population is insured under the regional/local budgets; regional administrations pay the regional MHIF an agreed rate for the nonworking population.

²Semenov, Vladimir, MD, PhD, Sheiman, Igor, PhD, and Rice, James A., PhD, "The Context and the History of Provider Payment Reforms in the Russian Federation: A Challenging Arena for Managerial Development for Twenty-First Century Russia," *The Journal of Health Administration Education*, Vol. 14, No. 2, Spring 1996, pp. 115-132.

In theory, the national-level MHIF was responsible for overall policy, implementation guidelines, and reallocation of a small percentage of the overall employer collection (0.2 percent of the 3.6 percent) to subsidize poorer oblasts nationwide and to guarantee coverage of the minimum mandatory package. The Ministry of Health continues to finance from its own budget certain categorical disease programs, public health (infectious disease and environmental hazard) services, research, training of health professionals, and special facilities (for TB, psychiatric disorders, and AIDS). Concurrently, legislative efforts were underway to devolve more responsibility to Russia's regions. The 1991 Law on Local Self-Management empowered regional governments (at the municipal, rayon, and oblast levels) to finance health care through regional budgets and to administer facilities under their respective jurisdiction. While the law was beneficial in promoting decentralized decision making and accountability within the formerly hierarchical bureaucracy, many Russian professionals and government officials view the law as "having gone too far" in the direction of decentralization; that is, it empowered a new group of political players without providing concrete, systematic guidance on implementation, relationships between parties, the necessity for coordination, etc.

The trend toward decentralization was accentuated during the preliminary implementation of the Mandatory Health Insurance Law at the oblast levels. In the opinion of many Russian health care professionals, the MHI law was implemented without guidance from the national level on the roles and responsibilities of local structures, the nature of a uniform benefit package, modes of financing and local administration, and the determination of services provided under budget funds as opposed to the MHI. The many different funding flows (budget, Ministry of Finance [capital expenditures], equipment budget, MHI contributions) require close coordination among the regional health care authorities and the MHI; to date, few have been able to agree to "pool" funding or even to plan expenditures collaboratively. Health authorities have often been reluctant to relinquish control over budget funding to the newcomer MHI Fund. During the evaluation team's visit to Ukraine and Central Asia, team members spoke with interviewees who widely admired the Russian example of health care reform but noted almost universally that reform occurred too fast without sufficient central control over the process and perhaps went too far in decentralizing authority.

In addition to organizational and control issues, both a decline in real spending for health care and the overall deterioration of Russia's economy have hindered implementation of the MHI law. Real spending and funding have decreased precipitously; in 1992, 4 percent of GDP was spent on health (low when compared with the OECD average of 8 percent); in 1996, approximately 1.4 percent was allocated to health.³ In the localities, only three of the 18 chapters of the health budget have been paid during 1996: salaries, medical services, and medicines. Wages, however, have been deferred to the point that some providers did not receive summer wages until fall 1996. The health care sector, as with other sectors, is unable to pay for energy costs and is currently in arrears. As is evident all over Russia, local authorities are experiencing difficulty with tax collections in that many industries are either "mothballed" or unable to pay employee wages, let alone social insurance taxes.

³Schieber, George J., "Health Care Financing Reform in Russia and Ukraine," *Health Affairs*, (USDHHS, Health Care Financing Administration, Baltimore, MD) Supplement, 1993, pp. 294-299.

B. ZdravReform in Russia

Against this complex backdrop, USAID charged the ZdravReform program with improving the Russian health care system by developing innovative “working models” that included

- C improved methods of finance and payment;
- C restructured modes of service delivery;
- C quality improvement activities; and
- C management information systems.

Among the assumptions guiding the program, two are noteworthy. First, ZdravReform would promote change “within the existing system.” Second, activities would be developed in response to counterpart needs and initiatives. The program focused on the oblast level in accordance with the above-mentioned decentralization of authority in the health care system. Even though the program was originally intended to assume a national-level liaison and policy dialogue role, early on such a role was eliminated because USAID did not believe that the national level was sufficiently supportive of promoting change in the health care system. At the time the decision was made, many influential Ministry of Health officials were interested in renationalizing health care, not addressing fundamental issues.

The program concentrated activities in two areas: the geographic focus area of western Siberia (the contiguous Kemerovo, Novosibirsk, Altai Krai, and Tomsk regions) and the Central Russian Tver and Kaluga oblasts. ZdravReform attempted to involve as wide a range of facilities within each oblast as possible, sometimes setting up “duplicative” activities in two or more facilities and in some cases combining a “fast track” grant with technical assistance. The program was able to assess variations and advantages/disadvantages in duplicate activities (i.e., hospital payment based on two variations of global budgets) as well as to ensure survivability if one facility had to withdraw from the program. The program attempted to introduce a variety of reform concepts to as large an audience as possible within Russia through both the engagement of multiple sites and a small grants program. Another program strategy called for using the highly skilled and educated Russian workforce. USAID and ZdravReform also tried to use as many local experts and consultants as possible in the provision of technical assistance. Where possible, certain aspects of the work (i.e., software development) were “contracted” out to local counterparts and organizations.

Within the pilot sites, the ZdravReform program focused on developing

- C quality improvement models for specific interventions and diseases and indicators for hospital and ambulatory care;
- C financial models that show improved cost-effectiveness, including model contracts between facilities and the MHIF, provider incentives, new payment models for hospital and primary care, and cost-accounting and financial management programs;

- C new models of service delivery intended to increase primary care and to redirect resources to outpatient care, including model managed care entities (Tula and Kemerovo) and freestanding family group practices;
- C information systems to support tracking of patient enrollment, utilization, outcomes, physician performance, payment, and quality;
- C extensive training in the United States and other health care systems with respect to health insurance, quality assurance, cost accounting, and clinical patient records;
- C targeted policy dialogue and legislative assistance at the regional and national levels; and
- C dissemination of project information and “best practices” health literature.

Most of the financial, service delivery, and quality reforms had been implemented as of October 1996, but many only recently. In some cases, budget shortfalls have prevented implementation of a critical component such as increased provider incentives. Dissemination of the program’s wide array of information and experiences began only within the last six months. In particular, a new USAID cooperative agreement has been funded to disseminate the ZdravReform documentation, and a local Russian organization is coordinating a conference on “results and lessons learned” from the ZdravReform experience for later this year. The ZdravReform program ends in December 1996.

USAID and ZdravReform have collaborated closely with World Bank projects in Central Russia (Tver and Kaluga are two of the World Bank’s intended recipients for the Russia Health Sector Loan, which is expected to be finalized soon) and with the Medical Equipment Loan, which focuses on health care facilities throughout Russia (several Siberian sites are scheduled to receive updated basic medical equipment and supplies). This successful donor collaboration has enabled USAID to “leverage” World Bank resources to promote health care reform and to ensure sustainability of USAID projects. ZdravReform has also collaborated in a more limited fashion with other USAID contractors, mostly notably with the Rational Pharmaceutical Management program (RPM). Earlier this year, RPM conducted several seminars on drug information and management systems for counterparts in Tver and Kaluga.

C. Grants Program

USAID designed the ZdravReform program to conduct a small grants program to fund entrepreneurial projects throughout the NIS. The program was used extensively in Russia and, to a lesser degree, in Central Asia. For the Russia program, ZdravReform conducted five solicitations and authorized approximately \$2.2 million to 38 grantees. The small grants program promoted a wide array of financing, service, and private entrepreneurial activities that raised public health awareness and promoted the development of service-oriented nongovernmental organizations (NGOs), including some of the first local health care

professional associations and advocacy groups. The grants program also stimulated counterpart involvement and a “buy-in” of reform activities.

The grants program was effective in supporting other technical assistance activity in the IDSs in addition to promoting the private provision of health financing, service delivery, and reform-related research in regions outside the IDSs. While the counterpart organizations interviewed rarely distinguished the regular technical assistance from the help received under the small grants program, the lack of differentiation may have resulted from the evaluation team’s schedule, which allowed for site visits only to grantees inside the IDSs.

In both Central Asia and Russia, the grants program rounded out already completed or deepened ongoing technical assistance programs. In some cases, it filled in resources where the regular technical assistance was unable to meet a demand. It brought new participants into the reform process and, in a number of important instances, added a civic participation element to the ZdravReform program by encouraging voluntary participation, helping popular organizations develop advocacy skills, and assisting NGOs in playing a larger role in providing social safety net services.

As with many of the various NGO-type grant programs throughout Eastern Europe and the NIS, nascent organizations that have received support need to be nurtured. In Central Asia, those cooperating with the ZdravReform program will have additional time to continue developing their organizational skills and learning about the world of grant writing, fund raising, membership development, and advocacy. In Russia, this work may be cut short, leaving the organizational development/civic society job incomplete.

D. Future Prospects: Health Care Reform in Russia

USAID/Moscow has outlined the following strategic areas for health care reform in Russia: restructuring the program of health care finance; reorganizing the system of medical service delivery; supporting the creation of enabling legislation and regulatory acts to codify the results of the experiments in health care sector reform; developing public/private governance institutions to manage reengineered service delivery and finance activities; and creating a climate conducive for capital investment to replenish the assets of the health care sector, albeit with a slightly different focus than ZdravReform’s oblast-level working model approach. From 1994 to 1996, ZdravReform addressed the first two strategies at pilot sites. Future activities in health care reform will focus on the remaining three strategic areas. These activities include national-level policy guidance and technical assistance to the Russian Duma (Parliament) and to the MOH on specific health care legislation, developing capital investment programs for the primary health care sector, and possible refinements to the Mandatory Health Insurance Program. As mentioned above, the ZdravReform documents and health information CD-ROMs will be disseminated under the new cooperative agreement.

II. SERVICE DELIVERY

A. Central Russia

1. Background

The Kaluga and Tver pilot projects brought together the providers of health care services (hospitals and polyclinics), community participants and planners (municipal- and oblast-level health committees), and payors for health insurance (Territorial Insurance Fund). The major tools made available to promote reform included technical assistance from Abt/Moscow and its consultants, grants to test various models of service delivery, and such training activities as seminars, workshops, and travel study programs. USAID also decided to provide technical assistance to support the application for a significant World Bank loan of approximately \$80 million to facilitate health care reform in Central Russia.

During the ZdravReform program, the macroenvironment external to the project was undergoing significant change as a result of economic deterioration and dislocation. Simultaneously, Russia was enacting new legislation on health care initiatives, particularly compulsory national health insurance. No one in the central Russian oblasts of Kaluga and Tver anticipated either the pending World Bank loan or early termination of the Abt contract.

2. Observations

During the startup of the ZdravReform program in Russia, several offices shared different responsibilities for program planning and operation, including Abt Associates/Bethesda, USAID/Washington, USAID/Moscow, and Abt Associates/Moscow. During the project period, three different Abt country directors oversaw the Russian Federation component of the ZdravReform program. At the time of this evaluation, no senior U.S. staff from Abt was in residence in Moscow. The project had largely concluded.

The ZdravReform program in Russia has been an extremely complex undertaking. The project has not only introduced an array of operational, financial, and service activities, but the Russian Federation's macroenvironment has been changing rapidly in terms of the economy as a whole and the health sector in particular.

The project has provided Russian planners at the local, rayon, oblast, and national levels with a significant body of contemporary information. Topics have included health maintenance organizations, managed care systems, quality assurance, outpatient surgery, daycare, medical economics, relative value scales, diagnostic-related groups, resource reallocation, cost-effectiveness, fixed and variable costs, outcome measurement, inpatient and outpatient computer data systems, information systems, consumer choice, medical and economic standards for quality control, biomedical communication systems, provider payments, capitation, fundholding, risk assessment, clinical patient record systems, contracting, clinical pathways, practice management, primary care, modern family practice, clinical protocols, professional certification, financial modeling, contract management, rate setting, resource management activities and insurance, case mix, and other topics related to health care financing and modern clinical practice.

Project inputs have included a broad range of technical assistance, grants to test new and innovative health care systems, study tours to U.S. health-related institutions, in-country

workshops and conferences, CD-ROM project information, and compilation and distribution/dissemination of shared findings (including translated technical articles and information). Numerous projects, pilot studies, and grants were implemented. The project is also responsible for a unique and important collaboration among the World Bank, the Territorial Fund, hospitals, polyclinics, and the Oblast Health Care Committee in Kaluga and Tver. With many grants under the project due to be completed by October 31, 1996, final grantee reports are not yet available.

From a technical perspective, Kaluga appears well on its way to meeting project objectives. Each of the institutions selected, including hospitals, the insurance fund, and the polyclinic, has internalized and operationalized the fiscal, quality, and economic elements identified by the contractor as important elements of system reform. Further, Kaluga widely shared the materials, tools, and elements of health care reform across the oblast through additional meetings and conferences. The entire Kaluga senior management team from the insurance fund down to the polyclinic praised the Abt team's technical help and overall performance. Kaluga's senior representatives seem ready and primed to continue the work of the project. The Abt staff clearly facilitated, nurtured, and aggressively empowered the Kaluga oblast health and political leadership. Although it is premature to assess the final outcome of health care reform, sufficient activities are in place to make Kaluga a future showplace for ZdravReform. Kaluga's newfound confidence and empowerment were in evidence as Kaluga officials actively participated in the World Bank's new project design and collaborated with Kaiser Permanente in the follow-on USAID project. Tver, the other World Bank recipient, was not visited by the evaluation team.

In Tula, a project grant enabled local provider groups to develop working plans for a health maintenance organization (HMO), remove legal impediments and obtain political support at the oblast and city level, and develop cost data for a separate polyclinic structure. Over 32,150 individuals have been assigned to a new flagship HMO, with architectural plans drafted for a new facility. Primary and secondary levels of preventive services were introduced to reduce the overall prospective disease burden on the HMO, capitation rates were calculated for children and adults under 55 and senior citizens over 55, and information was provided to both providers and patients about how HMOs function. The Albany Medical Center and Community Health Plan HMO of Albany, New York, has been pivotal to this effort and continues to provide technical assistance. The Albany/Tula relationship grew out of a longstanding sister city relationship. Albany HMO staff sit on the board of directors of the Tula Albany Insurance Company. Tula is now ready to move to full implementation of the HMO.

3. Assessments

The following three organizations will have a significant impact on the reform of health care in Russia:

- C Abt Associates, Inc., has provided the informational backbone and readiness skills that will directly and indirectly enhance the health care reform process in Russia. Abt has introduced many examples and ideas and disseminated much information

about modern managed health care, including financing and operations. Abt's significant pace-setting effort occurred from 1994 to the present.

- C Kaiser Permanente has in-depth experience in all aspects of integrated managed care systems and will assume from Abt the responsibility for continuing the USAID-supported health care reform program over the next three years.
- C The World Bank has just completed an assessment of ZdravReform activities in Central Russia and has agreed in principle to loan \$80 million to Russia for continuation of health care reform during the seven-year period 1997–2003. In summary, a rapid-action technical assistance firm such as Abt, with venture capital from the World Bank, translates into a strong, integrated functioning unit that is well positioned to address the organizational, operational, and strategy issues raised by the Russian health care reform project.

The Russian staff working under the project is highly competent and dedicated. Russian planners and organizations have been empowered to act on health care reform issues in Kaluga and Tver oblasts in response to the first-rate technical advice they received from the Abt staff. Abt's use of Russian professionals as technical assistance providers has been a highly positive experience for all concerned.

4. Summary

Abt's technical assistance and grant support in Kaluga and Tver oblasts has made possible the achievement of project goals and objectives. These oblasts are ready for the next steps. The participation of Kaiser Permanente with its extensive experience and depth of managed care should accelerate the achievements of the ZdravReform program. The World Bank loan will provide much-needed capital.

The project's newness and sheer size have provided the basis for many future lessons. Health care reform that relies on managed care models, relatively new methods of financing, and quality assurance practices and total quality management cannot be effectively implemented in less than a generation (about 20 years). The first steps taken by the U.S. government through the ZdravReform program are totally appropriate to the reform effort.

B. Siberia

1. Background

The evaluation team split into two groups to cover at least the major sites in the ZdravReform Siberian geographic focus area; one group visited sites in Kemerovo and Novosibirsk oblasts, another visited sites in Altai Krai and Tomsk.

The Kemerovo oblast is known for its leadership in health care reform. It has been the site of active experimentation for the past ten years. ZdravReform assistance allowed leaders in various health-related fields in Kemerovo either to move their efforts along at a rapid pace

or to try new technologies, including financial payment mechanisms, quality assurance systems, and information systems. In Novosibirsk oblast, where the reform process was less advanced, innovators used the technologies made available under the project to effect changes that were embryonic or nonexistent before the project.

Assistance provided by ZdravReform in Tomsk and Altai Krai focused on reforming the public health sector through the Oblast (or Krai) Health Care Committees, the Territorial Mandatory Health Insurance Funds, and local medical academic institutions. Although there are reported to be a few private practices and insurance companies in these areas, the team did not examine such features of the health care system.

2. Observations—Sites

KEMEROVO

In Kemerovo, the team met with officials from the Health Department, the Information (Computer) Center, the Territorial Fund, the Hospital and Medical Insurance Funds, Polyclinic #12, a dental clinic, and a large group from the Medical Insurance Association, including the counterparts from Tissul rayon, who came 300 km to meet with the team.

Kemerovo city and oblast health officials have been actively promoting health care reform for the past ten years. As a result, they were well prepared to receive assistance through ZdravReform and used the assistance effectively. Much progress has been made in reform, not only through the ten-year effort, but also through the boost the city and oblast received from the ZdravReform project. The sophisticated level of the information and health care financing systems is noteworthy, and the models now undergoing development are attracting considerable interest from other parts of the country and throughout the NIS. New models of financial and infrastructure reform, the development of billing capabilities, capitation distribution, and the collection of health data to be used for quality monitoring are all being tested. In addition, the formation of primary care practices (“general practices”) and outpatient surgery centers and the development of fundholding supplemented by certain incentive payment services (“home care” and “daycare”) are all creating rapid changes in the health care delivery system, much of it facilitated by the ZdravReform project.

The team observed several managed care projects in Kemerovo, the most impressive of which was the Tissul project. In the 18 months it has been receiving technical assistance, money, and training through the ZdravReform project, the Tissul project has developed a 35,000-member HMO with many of the features of a U.S. HMO. It has implemented a 36 percent decrease in hospital beds through a 22 percent reduction in admissions as well as decreased lengths of stay. It claims to have saved 1 billion rubles by reducing hospital use without reducing the level of medical services.

Like others the team interviewed, the HMO is sorry to see assistance under the ZdravReform program come to an end. Nonetheless, it has built a sustainable and replicable model for others to emulate. The HMO claims that as recently as one year ago, an integrated delivery

system seemed impossible; with the help of ZdravReform, however, the delivery system is now a reality.

One model in Kemerovo that appeared to be overrated was Polyclinic #12. Widely held up as a model of capitation (fundholding), it seems to have administrative software in place to run its business. In practice, though, its claims of programs for monitoring quality and adjusting physician payments based on outcomes (“final results”) are at best a work-in-progress and do not appear to exist. While Polyclinic #12 does collect some rudimentary health-related data, it showed no evidence of efforts to monitor quality. Conversely, the Oblast Dentist Clinic in Kemerovo seems to have in place a new practice management program that works and provides the structure needed for incentive payment billing—a new concept after years of a budget-based system. The clinic made no pretense of having a quality monitoring system in place; however, it did claim to be working with a group of dental clinics to set standards that may well improve quality and allow for its monitoring.

The Oblast Health Department provided considerable detail about a Kemerovo “Municipal Order” and “Oblast Order,” which is the authority assumed by municipal and oblast health officials for making the different parts of the health care financing system balance. The “orders” are needed to correct a serious cost-accounting problem that prevents true equity in the system as it adapts to a market economy. Although it was hard to grasp what these “orders” are authorized to do and how they function, there is an understandable need for someone to set the rules of the game in terms of balancing the budget funds for mandated services and the funds from the Territorial Funds for services to be provided by insurance.

At Polyclinic #5 in Kemerovo, which is setting up a general practice clinic, “general practice” means adult primary care with neither pediatricians nor obstetricians. The seven general practitioners in the general practice clinic had one otoscope/ophthalmoscope among them, one EKG machine, and not much else. Consultation rooms were equipped with only a blood pressure apparatus, thermometers, and an examination table.

In a satellite general practice of Polyclinic #5, three general practitioners were caring for a largely elderly population of 3,000 people. The building was a freestanding structure recently converted into a clinic. It lacked EKG and X-ray machinery but did have a small laboratory and a lot of electrical equipment as part of a physiotherapy unit—various kinds of electrical stimulation equipment. The facilities appeared to be circa 1930s standards for the United States and no better than what would be expected in rural clinics in India in the 1960s.

A cardiology center visited by the team, however, boasted fairly modern equipment, including Siemens cardiac catheter equipment and angioplasty capability. Yet the hospital rooms all had Oriental-type carpets on the floor—collecting bacteria with impunity. Working with the cardiology center, the ZdravReform project had conducted a study to prove that reducing the length of stay after myocardial infarction (heart attack) from the average 28-day standard to a 14-day standard had no adverse effects. In the United States, the standard for uncomplicated postmyocardial infarction treatment is seven days, reduced from 21 days 25 years ago. So far, the cardiology center has seen a reduction in disability time

from heart attacks from 120 days to 80 days on average and a 40 percent reduction in costs related to the earlier discharges.

Efforts such as reducing length of stay will eventually allow changes in the medical economic standards, which currently appear to constrain meaningful reform. For example, the current medical economic standard for a myocardial infarction diagnosis requires 25 to 30 days of hospital treatment. Unless a facility obtains a special exception from the insurance company, which the cardiology center succeeded in doing, providers do not receive payment for the full “finished-case” if they discharge a patient early.

NOVOSIBIRSK

In Novosibirsk, the team met with the Oblast Health Care Department chair and other representatives. They also visited the oblast hospital and municipal hospital.

The Novosibirsk Oblast Hospital is a 1,600+ bed referral and teaching hospital for the region. Its activity under the ZdravReform project was primarily a quality assurance effort in infection control. Members of the infection control team spoke with considerable knowledge about their adoption of quality measures for controlling nosocomial (hospital-acquired) infections. They largely credit ZdravReform and Dr. Stan Tillinghast for helping the facility reduce its rate of hospital-acquired hepatitis B and hepatitis C (which were being transmitted through improperly sterilized equipment), pneumonia (which was being transmitted through respiratory equipment), surgical wound infections, and maternity-related infections. The municipal hospital, also a large teaching facility, has applied quality assurance to a list of identified problems, which included reducing length of stay, decreasing surgical wound infections, the rational use of antibiotics, the introduction of a hospital formulary, and infection control. It has succeeded so far in reducing the length of stay from 17 days on average to 15 days and claims to have reduced cardiac mortality by one half in males with acute myocardial infarctions. These two Novosibirsk hospitals understand both the TQM methodology and the importance of quality assurance to running a modern-day hospital.

The team visited “ASOPO-ZHIZN,” a private insurance company in Novosibirsk. Formed in 1992, the company received a \$50,000 grant to set up a three-doctor general practice in a portion of a polyclinic newly renovated by the insurance company to provide a patient-friendly atmosphere for its members. The insurance company serves 320,000 members through the Territorial Fund and counts 22,000 members in a voluntary supplemental insurance program. The general practice is an attractive and patient-friendly setting for primary care. Patients interviewed briefly by the evaluation team noted that they are pleased with having their own primary care doctor. Conversely, patients waiting in the general waiting room for the polyclinic (not part of the general practice) stated that they would indeed like to have their own primary care physician.

ALTAI KRAI

The team visited both urban and rural sites in Altai Krai, including the Altai Krai Health Care Committee, Barnaul City Polyclinic #10, Troitsk Rayon Hospital, Gordeevo District Hospital

(a non-program hospital), and Novoaltaisk Rayon Hospital. The ZdravReform program had focused on a “fast track” grant to set up a multilevel system of care in the Novoaltaisk Hospital; developing a rural computer network at the Troitsk Rayon hospital; introducing computerized cost-accounting and budgeting to the Oblast Health Care Committee; assisting with the Licensing and Accreditation Committee of Altai Krai and with facility-level quality assurance initiatives; and training and equipping five independent family group practices.

The Oblast Health Care Committee (OHCC) demonstrated the cost-accounting software and stated that it was planning to develop the Krai’s 1997 budget by using actual costs derived from the software. Some work was also performed on developing a “rational” basic benefit package for the Territorial Mandatory Health Insurance Fund (THIF), but the team did not see it. The team did not meet with any representatives of the THIF and it was reported anecdotally that the OHCC and THIF do not interact closely with each other. The team also met with representatives of the Oblast Health Care Committee’s Bureau for Licensing and Accreditation, which had been active in developing ambulatory quality indicators under ZdravReform.

The team visited the Troitsk Rayon Hospital, which also manages three polyclinics and ambulatory facilities, several smaller district hospitals, and 28 feldsher-midwife health points (FAPs). One of the hospital’s main activities under the ZdravReform program was to create a “model” rural health system computer network. The Health Committee allocated six of its allotted 15 computers to Troitsk in order to test the feasibility of creating and sustaining the computer system in a rural hospital environment. The project benefited from the fact that the Troitsk hospital already had several computers in operation for accounting purposes. The added advantage of selecting this site was that the rayon chief doctor was facile with and supportive of the use of computers in his facility. A file server and a communications server were installed in the computer network. Due to the incompatibility of the preexisting Russian software and hardware, Troitsk was unable to tie into the new local area network with the Russian system. Troitsk now has a total of 15 computers and ten printers with 30 doctors and nurses trained by Medprofilactika, the state-run computer services company. The “hard wiring” of the facility and the installation of the system also was performed by Medprofilactika. Troitsk coordinated its work with Kemerovo, which experimented with installing and supporting a computer system in an urban area. Troitsk also planned to convert several of the outlying FAPs to freestanding family group practices, which in turn would be linked to the rural computer network.

Beginning in September 1995, counterparts in Altai Krai established five family group practices, two located in city polyclinics, two within polyclinic and hospital complexes, and another in a rural ambulatory facility. Due to funding shortfalls and a lack of coordination between government agencies (including the THIF) responsible for local health budgets, the Krai was unable to implement the proposed per capita payment system, which would have introduced a monetary incentive for family practitioners. The team visited a family group practice located in Polyclinic #9 in Barnaul City in which three family doctors and two nurses were working since late September 1996. The practice served 8,000 people assigned by the catchment area. The OHCC had used part of the ZdravReform grant to equip the family group practice, but unfortunately, the counterparts were unsure whether they would

be able to maintain the supplies. The OHCC had developed a capitation rate (170,000 rubles/per person per year) for the family group practices to provide outpatient services under partial fundholding; however, the Krai did not receive sufficient budget funding to implement the capitation. The family practitioners were supposed to receive an additional “bonus” payment to supplement their salaries, but it has not materialized. ZdravReform economists thought the incentive from this proposed nominal amount would not be as effective as a payment based on quality or performance per patient. So far, Altai Krai family practitioners claim that “professional satisfaction derived” from treating patients more comprehensively has been the chief result of the reform. The team feared this arrangement would not be sustainable and that providers were not being adequately rewarded yet (as in Issyk-kul) for increased responsibility and workloads and delayed salary payments. The physician showed the team the “comment book,” which was filled with patients’ glowing accounts of the family doctors. The OHCC is currently developing a survey to track patient satisfaction and to introduce ambulatory quality indicators.

The Novoaltaisk Hospital visited by the team demonstrated some of the difficulties of transitioning to the Russian MHI from a norms-driven system. With ZdravReform assistance, the hospital determined that it could easily reduce 30 percent of beds and use the associated savings to provide bonuses for physicians. In Altai Krai, however, the budget for facilities is still based on the number of beds and physicians. There is little incentive to close these beds as the facility would lose 40 percent of its budget. Even so, the approved hospital budget for FY 96 was 60 percent of that requested; of this 60 percent, the hospital had to date received only 40 percent. The funds were authorized to pay for salaries, food, and medications only.

Despite the severe funding shortages, the Novoaltaisk chief physician has introduced internal cost-saving procedures and manages to reallocate funds unofficially within fixed budget allocations to provide staff incentives. The hospital has streamlined drug procurement and utilization by implementing an essential drug list containing only 100 of the 300 to 400 drugs that used to be routinely ordered. Clinical practices are also changing to favor the most cost-effective approaches; the chief physician mentioned that oral therapies were more frequently given than injections, as tablets/pills were generally cheaper and safer than injectables. The chief physician has also managed to introduce a system of bonuses for physicians that are linked to the quality of performance and use existing salary funds. Novoaltaisk counterparts noted that in addition to the budget shortfalls, part of the problem in reforming health care delivery was the relative novelty of the MHI system and lack of experience on the part of the THIF. The multilevel system of care, which included plans to reduce length of stay, determine levels of acute and subacute care to be provided by the hospital (possibly to create a parallel, less costly ambulatory facility), and develop payment rates for various types of hospital care, has not yet been implemented.

TOMSK OBLAST

Unlike Kemerovo oblast, which was famous throughout the former Soviet Union for its innovations in health care, Tomsk oblast was characterized as a “blank slate” in which assistance from ZdravReform in short time achieved an almost complete mindset change and

commitment to reform among health care administrators. Tomsk was unusual in the degree of collaboration between the Oblast Health Care Committee (OHCC) and the Territorial MHIF, which promises that the reforms so recently started will continue and succeed. Under the leadership of the OHCC, a special health care reform coordinating committee had formed, which even included the Ministry of Finance and had recently approved a five-year plan for health care reform in the oblast. The OHCC and THIF planned expenditures jointly.

The primary elements of reform in Tomsk were cost accounting and financial management; resource management within facilities; establishment of family group practices with provider incentives and utilization management; introduction of global budgets for target hospitals; computerized budgeting, patient utilization, and insurance tracking; and quality assurance indicators. In addition, the Siberian Medical University (SMU) located in Tomsk had developed a family medicine specialty and clinical refresher training. SMU had also developed a higher education program for nurses (unique) and a health management degree. Tomsk developed a legal concept, outlining the roles and responsibilities and reimbursement for new family doctors.

The evaluation team met with representatives from the Oblast Clinical Hospital (OCH) and Municipal Hospital #3, which were using the step-down cost-accounting method created for them by ZdravReform. In June 1996, these facilities had implemented global budgets for inpatient care; OCH's was a global budget based on medical economic standards while Municipal Hospital #3's was a global budget based on a per finished case basis (similar to the DRG system). According to the deputy head for economics from Municipal Hospital #3, the hospital was maintaining two cost-accounting systems: one was the required state system and the second was the new pilot system, which was tracking expenditures and costs for the global budget system. Tomsk counterparts strongly emphasized to the evaluation team the value of knowing their costs. It "opened their eyes" to the possibility of attracting patients for greater reimbursement and to the possibility of cutting costs through reduced lengths of stay and savings in energy and facility-specific costs. Both hospitals were negotiating risk-sharing contracts with the THIF; during the team's visit, the hospitals were considering a 15 percent risk corridor for nonplanned cases if the hospitals could confirm that their rates were based on actuals.

Concurrently, the Oblast Health Care Committee was working with the hospitals to introduce quality assurance programs in four main areas: reduce length of stay for peptic ulcers; develop a drug formulary for treatment of ulcers; treat urologic conditions; and introduce QI procedures for new surgeries. By lowering the average length of stay for certain conditions, the hospitals planned to use the savings for personnel bonuses. The Health Reform Coordinating Committee was developing a unified approach for quality improvement for insurers, the THIF, and the OHCC and protocols for 20 main diagnoses for family practices.

The team also visited an independent family group practice located within Polyclinic #10, the largest polyclinic in the city with a catchment population of 50,000. Three family practitioners with three practice assistants, who were recent graduates of the Siberian Medical University program, had been working as a practice since June 1996. They were paid a capitation rate, 62.7 percent of which was funded by THIF; municipal funds covered

the remainder. Patient data and services were tracked through a computer network that linked all polyclinics. The practice was planning to open a bank account in the near future. The unique feature of the family group practice was that it was able to control patient utilization of outside services. Patients are registered to the family group practice and are obliged to obtain authorization for referrals to specialists and outside services through the “gatekeeper” family group practitioner. The family group practice maintains continuity of care by tracking referrals, making appointments for patients with specialists, and following up with patients to make sure they received good care. Preliminary data suggest that, in only a few months of operation, the polyclinic’s specialists, who formerly would have treated the family group practice’s patients on a fee-for-service reimbursement basis, were experiencing a decline in income and referrals.

3. Observations—General

Health Care Financing. The principal financing mechanism in Russia has been territorial funds established at the local or oblast level. In a few oblasts, local officials have attempted to unify the budget and all funding of the health care system under the territorial funds, including payroll taxes collected specifically to finance health care and regular funds earmarked in the oblast budget for financing the health care of the nonworking. Despite its questioning several territorial fund and health care representatives, the team was unable to fix responsibility for collection of the payroll tax funds. All respondents agreed, however, that there was mass tax avoidance, and some of the health care managers alleged that as much as 35 percent of the taxes for health care remains uncollected. If the territorial fund is indeed responsible for the collection of taxes, then it needs additional assistance in collection techniques. In those oblasts where oblast budget monies were not directed through the territorial fund and where tax collections were low, the work of the territorial fund was chiefly theoretical, with little money flowing. In those Territorial Funds where budget and tax monies did flow through the fund, it was evident that some of the money was being diverted to build the fund’s offices and to furnish insurance facilities.

It appears that the territorial funds are in reality reallocation agencies for budget and health tax funds according to a formula developed and designed to incentivise hospitals to become more efficient and efficacious. No actuarial function exists in establishing the premiums and risk concepts used by the fund.

Quality. While the main purpose of quality review is to influence the medical approach and logic of treatment at the individual level, most of the quality assurance work examined by the team had taken on a decidedly “Russian twist.” Russian health care providers with whom the team met viewed “quality review” largely as “quality control.” Even though they were sensitized to the concept that quality control should not have a punitive aspect, it became apparent that punitive actions are used. The Russian counterparts estimated the annual fines on health care workers at 1 to 3 percent of the total hospital budget. Further, much of the quality effort centers on developing treatment protocols for different medical diagnoses largely in an effort to control physicians as opposed to encouraging the most efficient and efficacious way to treat patients. The system discourages doctors and health care workers from deviating from the protocols. The development of medical judgment, which includes

the concept that a physician can deviate from a protocol without penalty (as in the United States), is not part of the quality development effort in Russia. In the Altai Krai territory, the Health Care Committee performed a retrospective quality audit of 140 patients. All of the medical records evidenced problems that fell into three categories: diagnosis problems (47 percent); treatment problems, i.e., did not follow the protocol (42 percent); and breach in continuity of care, i.e., the appropriate level of care (22 percent).

For example, in the Altai Krai territory, the Bureau of Licensing and Accreditation of the Oblast Health Care Committee was made responsible for the licensing and accreditation of facilities, the certification of professionals, and the supervision of professional and institutional performance. Local health officials saw this as shifting the control over physicians from the hospital line officials to the new quality agency. At the same time, one of the avowed reasons for establishing territorial funds in the oblasts was to provide a source of control over the physician outside of the OHCC. Many of the changes held up to the evaluation team as health care reform had a strong element of control. It is as if the uncertainty created by the changes already underway and those proposed in the health care sector are creating demand for more control from oblast and municipal health officials, health providers, and the general local-level political leadership in Russia.

Clinical Practices. Changes to the clinical approach to treatment must occur at the local level but must be directed at individual performance. Abt's approach, which called for focusing reform and change of health care delivery management at the oblast level in accordance with a 1991 law dealing with delegation of health care management, reinforced the authority at the oblast level. Abt should have devoted more effort to the individual or physician level. One of the needs of Russian professionals is to close the gap between their level of medical knowledge and contemporary medicine's level of knowledge, which translates into greater autonomy for doctors inside the system.

4. Assessment

The multiplicity of models initiated under the ZdravReform program has planted many seeds that are flourishing and providing models for others to follow. Many of the models have taken hold. In fact, the team saw repeated examples of problems solved in response to the assistance provided by the project. No one project was so expensive that it cannot be replicated. Further, the models' ability to draw the attention of people in other parts of Russia and the NIS is encouraging even though the broad geographic focus area (GFA) may have presented logistical challenges. The project's shotgun approach has worked well in a remarkably short period. The project realized a good return on investment, but concerns remain that much of what started could wither on the vine without adequate follow-up.

The project made effective use of host-country experts. In particular, Igor Sheiman and Tatiana Makarova were outstanding project consultants. Their continued participation would greatly enhance the sustainability of the project.

Finally, the old-style polyclinics seem too bureaucratic to be a useful base on which to superimpose meaningful innovation. Reliance on competing provider units would more effectively spur change.

5. Summary

The ZdravReform project has been remarkably successful and has produced numerous examples of meaningful change in the shift from a controlled economy to a market economy. It is well worth continuing if at all possible. The Siberian subprojects (specifically Kemerovo) were especially effective in that they took advantage of Siberia's ten-year experience with health care reform. It would be a shame not to provide continuing assistance in some form to ensure the sustainability of those subprojects.

The major concern about potential failure is not that the current assistance will not have its desired effect but rather that the whole economic system is floundering and could well collapse. That, however, is well beyond the scope of the project or the evaluation.

III. MANAGEMENT INFORMATION SYSTEMS

A. Introduction

The ZdravReform project was not an MIS project. For that reason, the MIS products should be evaluated on two levels: the quality of the deliverable as an MIS product and the effectiveness of the MIS products in supporting the health care reform goals of ZdravReform. The seven major ZdravReform MIS products follow:

- C **Territorial Fund Systems**—intended to support financing and payment reform.
- C **Clinical Patient Records Systems**—intended to support quality assurance and integration of finance and medical statistics.
- C **Computer Equipment Procurement**—intended to provide hardware/software to support ZdravReform objectives at various sites.
- C **CD-ROM Project**—intended to support information dissemination.
- C **MIS Plans for Kaluga and Tver**—intended to support overall planning as well as requests for funding from the World Bank.
- C **Hospital Cost-Accounting Software**—intended to support promotion of cost-accounting techniques in hospitals.
- C **Small Grants**—intended to provide small grants programs that extended to MIS support.

B. MIS

1. Positive Observations

- C The software/hardware support was critical. In addition to providing opportunities for operational efficiency, the data to be generated by the MIS will form an information base on which to build. One of the primary benefits of ZdravReform was an increased understanding of the proper role of MIS within the health care delivery system and the health care reform effort. For the most part, the sites are only beginning to make effective use of MIS.
- C Local government economic and health professionals in the oblasts repeatedly cited the provision of on-site economic analysis based on local data and conditions as critical to the reform process. The ability to provide this analysis, combined with the introduction of computing equipment and skills, augers well for the future.

2. Areas for Improvement

- C The delay in computer procurement in Russia hampered many projects. Only as the project was coming to an end were the computing resources becoming available, thereby making it impossible to provide any guidance in their use following initial delivery and setup. Such guidance would have been particularly useful at the less experienced sites. It takes time and training to turn these “toys” into tools.
- C If government procurement rules permitted, the procurement delays could have been used to advantage in terms of upgrading the equipment. The specifications originally called for 486 processor machines. While appropriate at that time, those specifications should have been revised to Pentium class. Further, the procurement did not call for CD-ROM drives for most of the equipment. While perhaps an oversight, the Abt project team should have addressed this issue later since a major MIS project deliverable was expected to be a CD-ROM.

C. MIS Products

Each of the seven major MIS products is discussed in terms of its design, implementation, management, impact, and future.

1. Territorial Fund Systems

The primary software development site is the Information Center in Kemerovo. However, similar software is undergoing development at the Territorial Fund in Kaluga.

Design. Like the clinical patient records system, the Kemerovo software development system is built on previous work. It appears to be well designed, but it is impossible before implementation or without extensive tests to determine how

well it will perform. Given good database design and application programming, the selection of Oracle as the database engine ensures that the system will be able to support large volumes of data and lend itself easily to data analysis.

From a project design point of view, the selection of the Information Center for the software development work was a good one. The personnel have a happy combination of technical skills and knowledge of health care. Kaluga has benefited from visits by Information Center personnel, who have been extremely helpful.

Implementation. As neither system has been implemented, it is impossible to offer comments on operation. Kaluga is still working on its system and faces the difficulty of finding funds for the purchase of multiple copies of Informix, its choice of database software to be run at all territorial fund branches. The Information Center in Kemerovo is waiting for its server, an RS/6000. An initial delivery was defective and had to be returned for repairs. Kemerovo's intent, when it receives its server, is to proceed with final software testing and tweaking on the RS/6000 and then to begin building a database for analysis purposes, bringing in data from the Territorial Fund and, over time, from insurance companies and providers. The software will also be installed at the Territorial Fund itself but awaits the purchase of an AS/400 server. It is not clear when the purchase will occur.

Management. Whether in Kemerovo or Kaluga, ZdravReform has not directly managed the MIS project. Therefore, it is difficult to judge whether the allocation of management resources would have been productive or even welcome. There is concern, however, that Kemerovo has built its system using Oracle while Kaluga plans to proceed with Informix as its database software. Both should have used the same system. Another concern relates to cost. Oracle and Informix are not inexpensive. Given time, a better option would have been to develop limited database capacity systems for use at the branch offices. This would reduce the expense for those sites while still allowing for a full-strength database at the central site. A comparatively inexpensive product such as Microsoft Access or Paradox could have been used for the branches.

Yet another question relates to the decision to install the Kemerovo-developed software first at the Information Center rather than at the Territorial Fund. Since the major purpose of the software is to support the operations of the Territorial Fund, it would have been more effective to install the software first at the fund.

Impact. Impact is hard to judge before implementation. Certainly, the time spent developing the new software in the context of health care reform should ensure improvement over existing systems.

Future. The plans for an oblastwide analysis database may in time prove more useful in a strictly reform context than the operational software developed at the Territorial Fund.

2. Clinical Patient Records Systems

The primary development sites are Kemerovo, Barnaul, and Tomsk, with a similar effort at Hospital #5 in Kaluga.

Design. As with the Territorial Fund software, little can be known for sure until the software has been in use for a while. The software choice in Kemerovo was Paradox for Windows, a perfectly good database product. As with the Territorial Fund software, the design is not new but rather builds on the “Arena” software, which has been in use for over ten years.

Implementation. Implementation is hampered by the need to rekey data from the old system. At Polyclinic #12 in Kemerovo, staff is still rekeying old data into the new system. In short, the new software is not yet fully operational. The polyclinic staff noted that it was not possible to load the data automatically from the previous system. Assuming incompatible file and field layouts, that is probably true.

At Hospital #5 in Kaluga, the team visited the Information Center, which employs a data entry clerk and a programmer. They have now prepared a patient records system that uses Access. As in Kemerovo, however, piles and piles of old forms must first be entered into the system.

Management. The insistence on entering all existing data is delaying the effective use of the software as well as the inevitable modifications that will be needed to ensure the system’s proper operation. A better approach would have called for entering new data at the outset, followed by entry of the existing data as time permits. If the resources had been available, ZdravReform should have worked with the sites to prepare implementation/transition plans.

Impact. Until the system’s full implementation, it is hard to make a judgment as to its impact. In an example of a new technology grafted onto existing procedures, Polyclinic #12 plans to require paper forms to be filled out before entry into the system by a data entry clerk. Better preparation could have helped the polyclinic omit this stage.

Future. Given full integration of the software into clinic operations, the clinic should eventually have access to better data that will improve both planning efforts and operational efficiency.

3. Computer Equipment Procurement

Procurement of computer equipment refers to the single large order placed by the ZdravReform project and the various small grants, such as that in Kaluga, for procurement of computer equipment.

Design/Implementation/Management. The two issues relate to process and content.

Process. As already mentioned, the acquisition of computer equipment was delayed almost until the completion of the project. That the delay was a detriment to various project activities is not in dispute. It seems apparent that the counterparts, the ZdravReform team in Russia, and Abt/Bethesda either did not completely understand the USAID procurement process or followed it incorrectly. To determine exactly where and why the bottlenecks occurred would take a great deal of research and likely not serve any good purpose. The problems can probably be apportioned between both Abt and USAID procurement personnel. At some point, either USAID or Abt should have stepped back and said, “Hold on, what’s the problem here and how do we fix it?”

A different topic under process is the method employed to develop the original specifications. Apparently, the Siberian sites, under the leadership of the Information Center in Kemerovo, had free rein to draw up the list of what they wanted within certain financial parameters. This may or may not have been a good idea, and perhaps the Abt project team employed more oversight than it appears. But with the later delays, Kemerovo began to sense that its involvement was slipping away. It would have preferred the Pentium machines. In fact, Kemerovo had selected Digital as the vendor for the servers and had traveled to Moscow to negotiate with the firm. Kemerovo still does not clearly understand how the Digital Alpha Servers became IBM RS/6000s. The reasons are in all probability valid, but Abt has not communicated them clearly to Kemerovo. Likewise, Kemerovo does not understand the reasons for the delays and what was done to remedy the situation. If the original intent was to vest responsibility and “ownership” of the choices in the ultimate recipients, then it was later undermined as the USAID procurement process took over and USAID made changes.

Content. CD-ROM drives should have been included in the order from the start or at least added later. Likewise, given the delays, Pentium processors should have been substituted for 486 processors.

Impact/Future. Clearly, the impact will be positive. One item that could leverage that impact would be the provision of software training. For some sites, beginner and advanced classes in Excel, Paradox, and Oracle would be an inexpensive way to increase the value of the hardware and software provided.

4. CD-ROM

The team was given a demonstration of the CD-ROM product at the Abt offices in Moscow. The product has not yet been distributed to the field.

Design. Using Microsoft Media View Tools, the vendor has created a highly professional product. The content, consisting of 220 articles, has been expertly

formatted and designed. The demonstration was performed on a high-end Pentium machine. Although not every site in the field will have access to that level of performance, it seems reasonable that performance degradation will be minimal. In truth, 220 articles and 8,000 pages do not require a high-end processor to ensure acceptable performance.

USAID intends to issue a second CD that will contain the various manuals and documents produced by ZdravReform. The CD would include documents issued in both Russian and English and would provide separate search engine capabilities for the Russian and English language sections.

Implementation. The production of the CD-ROMs was not yet complete; for this reason, implementation has not yet occurred. One problem will be the placement of the CD-ROM. Since the desire is to have the health care professionals use the technology, it must be made accessible as well as attractive to use. Mr. Roman Zelkovich, director of the Information Center in Kemerovo, suggested an approach in which he plans to excerpt certain articles and place them on diskette to increase distribution. He also plans to make available hard copy prints.

A note about CD-ROM drives is in order. As mentioned earlier, it would have been preferable to include CD-ROM drives as a matter of course in the newly ordered PCS. Most locations, though, already possess at least one CD-ROM-equipped PC. Locations such as Tissul, however, will be handicapped by the lack of a CD-ROM drive.

Impact. The degree to which CD-ROM technology proves useful is likely to hinge on its access to the health care professionals who are expected to use it. If it becomes only a “toy” in various computer centers to be shown off to visiting dignitaries, it will fail.

Future. While the provision of the two planned CDs should have a favorable impact, the disks should be seen as a the start of a formalized information dissemination mechanism. USAID should consider an investment in the use of the Internet for purposes of disseminating health care reform concepts and other medical data. If a “subscription” list of sorts could be developed throughout Russia, it might be feasible to produce the CDs on a regular basis, say, every four months. The objective would be to find a way for such an enterprise to become self-sustaining after startup.

5. MIS Plans for Kaluga and Tver

Russian consultants contracted under ZdravReform prepared the MIS plans for Kaluga and Tver. The team did not have an opportunity to discuss the plans in detail while in Russia and did not review them. It appears that the MIS plan for Tver has not been approved and seems to be bogged down. Kaluga’s plan, however, has been approved. Since one of the primary objectives of the plans was to support requests for funding from the World Bank,

the fact that funding has been approved for Kaluga means that at least the project met one primary objective. It was not yet clear, however, whether the plan adequately reflects true needs, supports valid objectives, and can be implemented.

6. Hospital Cost-Accounting Software

In the Abt/Moscow offices, Ms. Tatiana Makarova showed the team an Excel-based hospital cost-accounting spreadsheet. It was developed for use in Tomsk, Siberia, but has been distributed more widely. In fact, Ms. Makarova reported that more than 100 diskettes have been distributed. Though simple, the spreadsheet is well designed and could constitute a major advance for many institutions.

7. Small Grants

A number of small grants provided under ZdravReform provided funding for such MIS objectives as computer procurement. An example was Grant 434 to the Kaluga Mandatory Health Insurance Fund. Results have been discussed under Territorial Fund Systems and Clinical Patient Records Systems. In Kemerovo, Grant 426 to the Siberian Fund of Management Development went in part to the preparation of four modeling (what if?) programs used in the fund's training course. The programs provide experience in working with insurance, medical statistics, and health care economics. It is interesting to note that staff of the Information Center in Kemerovo prepared the programs. Two grants (408 and 414) issued specifically for information systems went to Vladivostok and Sverdlovsk, which were not on the evaluation team's itinerary.

D. Summary

As with the entirety of ZdravReform, the MIS component of the program must be viewed as a work in progress. The true impact and results will not be apparent for a few years. Considering the amount of time during which the project was fully functional in the field, the accomplishments have been substantial. Mistakes were made, and other approaches might have been more successful in some instances. Still, the several accomplishments provide a basis for building for the future. Even in the absence of any meaningful follow-up support, the MIS component should be judged an overall success.

IV. DESIGN AND MANAGEMENT

The original design of the ZdravReform project as first presented to the Russia Mission changed considerably to fit the Russian environment and, as a result, led to a series of conflicts over project management between the Mission in Russia and, at various times, USAID/Washington, the Abt team in Russia, and Abt/Bethesda. The original Russia design envisioned a project with a strong national-level focus. The Mission felt an oblast-level focus was more appropriate as a response to a 1991 law that delegated the management of health care to the oblast level.

The Mission subsequently “carved out” the “national aspect” of the project and handled it as a separate activity. Abt, however, was chosen to perform the national-level work by relying on Western consultants. The Mission gave no clear reason as to why it withdrew the work from Abt, except that the “Mission did not have confidence in Abt.” This position seems to contrast with the Mission’s feelings that the Abt/Moscow team had performed well. The little work performed on the national level was conducted directly by the Mission with some assistance by the Russian counterparts.

The original project design also proposed that Western consultants would perform most of the work, though with the assistance of some Russian counterparts who would become the conduit for disseminating results. The Mission reversed the original approach and wanted more Russian counterparts and fewer Western consultants as a means of improving the chances for sustainability. The Russian counterparts, clients, and the Mission agreed after the fact to the change in direction. Abt did not disagree with the approach, although it did disagree with the manner in which it was imposed. Everyone interviewed, including the Mission, praised the U.S. consultants used by Abt. The Russian counterparts particularly praised the Western expertise.

Another aspect of the original design that the Mission insisted on changing was the use of intensive demonstration sites, defined as single oblasts. The Mission felt that Russia was too geographically diverse to use the narrow definition of the IDSs or single oblasts. It insisted on geographic focus areas (GFAs) comprised of larger numbers of colocated oblasts. The focus on larger areas proved to be a more workable management arrangement in terms of project logistics and gave the work more critical mass and mutual support by involving neighboring oblasts in devising solutions to their health care reform issues.

The GFA concept also allowed for “a redundancy of experiments,” which most agreed was necessary given Russia’s diversity and complexity. Differences in approach and management are emerging in the oblasts in reaction to local political, economic, and health care delivery forces and comport with U.S. experience that health care is best handled as a local issue. However, no efforts were made to ascertain how many redundant tests were statistically necessary to validate results so that various experiments could serve as models for replication.

The original RFP asked for a project that highlighted privatization and financial reform activities. Again, at the insistence of the Moscow Mission, the concept was revised to one

of service delivery reform (named “quality”) and financial reform undergirded by the development of MIS capability. One of the reasons given by the Mission for the design change was that a certain amount of health care financing reform had occurred in Siberia before the fall of communism yet had failed because the Siberians had not included patient delivery reform and MIS developments. The Siberian counterparts supported the Mission’s revised concept, although they felt the failures were also attributable to the reluctance of the Central Russian Ministry to allow individual reforms to occur, the fact that reforms had been theoretical only, and insufficient funding to enact the theoretical findings.

Both Abt and the Mission agreed that the broader concept was the better approach. The greatest hurdle now facing the Russian system is how to inject new money into the health care system. The likelihood of new money in other than the long run, however, is remote and may call into question the sustainability of some of the experiments. The national or oblast budgets cannot begin to offset the reduced level of funding. New taxes for health care, while on the books throughout Russia, generate funds only when they can be collected. Therefore, to obtain “new money,” the hospitals and polyclinics must change their clinical and support delivery systems to become “more efficient” without sacrificing quality in the process.

Abt worked with other donors to leverage new project money. In Kaluga and Tver, the World Bank will assist the “roll out reform.” Unfortunately, the Russian counterparts felt that the oblasts could not make funds available to sustain the reform beyond that required to attract the new World Bank money.

The original design concept was “one of the work being coordinated on a national level and being rolled out to the local areas.” The Mission changed the concept to reflect a bottom-up approach. Russian counterparts all agreed with the Mission’s approach. In addition to the decentralization of health care delivery, a preponderance of the money necessary to support health care is generated at the oblast level.

The key project inputs in Russia were technical assistance training, study tours, and small grants. All seemed to work well, and in most cases Russian counterparts did not distinguish in clear terms one form of help from another. Most felt that all of the tools were required to achieve reform. As one respondent stated, “It’s all education and training to us. Even the technical assistance served as a training tool.” Several respondents stated that the “study tours” were turning points for them. They had read the literature and discussed the concepts. However, it was not until they went to the United States or Great Britain (to see the “fundholding” concept) that they understood the concept and how it could be applied at home. Another example is “quality.” Several counterparts interviewed by the team felt that they did not initially understand the concept of “health status indicators” except for overall mortality and morbidity statistics, much less “quality.” After the study tours and with Abt’s assistance, they have come to understand the concepts and how they link to efficiency, outcomes, and patient satisfaction. It should be noted that no results were presented to support the notion that, in fact, health status indicators had been incorporated into the planning, management, and evaluation of the Russian work.

In addition to the severe lack of funds for health care (both budget and tax resources), the project faced other external obstacles in attempting to rationalize the health care system. For example, project activities were hampered by certain rules and practices governing employment, budget development, and hospital management, some of which persist from the former Soviet command and control system, and, if left alone, may lessen the effectiveness of reforms.

An important element of the project design was to improve efficiency by providing monetary incentives to health care providers, rewarding providers who provided efficient and high-quality care. The most effective providers would then be treating a growing number of patients, leaving the less effective providers behind. Downsizing of excess capacity in the health care system would result from increased knowledge of facility costs and quality as managers weigh priorities. However, layoffs of personnel will be problematic for a number of reasons and may not bring the projected savings. For instance, in Russia, “salary and benefits” equal 22 percent of the cost of health care, with supplies, medications, and utilities representing the larger costs. (For comparison, “salary and benefits” in the United States equal approximately 55 to 65 percent of the cost of hospital care.) In Russia, labor is usually considered a fixed cost (at least 90 percent) as opposed to a variable cost in the United States—because it is almost impossible to fire or lay off employees in Russia. Currently, some health care administrators candidly acknowledge that facilities are overstaffed and/or inappropriately staffed (too many specialists, etc.) and that layoffs may be necessary. However, most are relying on workforce attrition and retirements rather than resorting to the politically disastrous alternative of laying off employees who have not been paid for months at a time.

In some areas, the current hospital payment system is still based on a per bed approach, which coupled with the other disincentives, practices, laws, and regulations, prevents health care officials from implementing such reforms as reducing the number of hospital beds. As a result, some of the experimental pilots would introduce a tool—a cost-accounting and financial management system, for instance—and learn actual costs for the first time. Although managers may realize from the new cost data that the facility has too many unoccupied beds, they are unable to reduce them for fear of losing a significant portion of their annual budget (which, by the way, is determined according to old formulas specified by the Ministry of Finance rather than by the Ministry of Health) because they are being reimbursed on a per bed basis. While cost accounting pointed out many opportunities for efficiency, many opportunities could not yet be realized.

It appeared to the evaluators that the project did not focus on teaching counterparts how to achieve cost efficiencies in purchasing, standardization, utilities, conservation or cost reductions, and dietary practices as they affect quality. The project performed some work in formulary development as a cost element, but several of the Russian clients stated that the above cost efficiencies were not a focus of their concerted efforts. An example of successful cost savings came from Tula, which undertook cost reductions when the health committee converted part of its unused space into rental property and transferred the cost of the space and allocated utilities to the new tenants. In addition to serving as “new money” in the system, a strategy of removing unused space from the health care system would have the

additional benefit of reducing the “cross-sectoral arrearage problem”— in this case, the health care sector’s indebtedness to the energy sector.

V. RECOMMENDATIONS

A. Project Design

1. While much of the rhetoric surrounding the ZdravReform program in Russia referred to the effort as short term, health care reform in Russia is a long-term undertaking at both the micro/oblast pilot site level and the macro/national level. USAID should not expect results other than “a good beginning from the work.”
2. The Soviet prekaz system mandating care interventions per diagnosis (including length of hospital stay, procedures, etc.) continues to inhibit family practitioners in their treatment of patients and their attempts to treat patients in less costly outpatient settings. In addition, a similar approach to quality assurance focuses on policing providers in their adherence to strict, process-oriented standards. Further assistance in quality assurance should focus on patient outcomes. Such an effort would benefit from examples of approaches used in different regions.
3. ZdravReform staff in Central Asia and Ukraine and future Kaiser Permanente staff in Russia should share experiences in relevant fields. For instance Central Asia, Ukraine, and Russia should cooperate on family medicine training (as all regions have addressed this issue) and on issues of medical effectiveness and quality assurance.

B. Project Management

1. If the models, subprojects, and grants are to be sustainable, they will require continued support in the form of users’ groups or additional assistance from the Russian consultants already in place. The various efforts do not necessarily need U.S. consultants or large infusions of dollars. To discontinue support now, however, will guarantee failure of the some of the projects. USAID should arrange some informal public/private partnerships that use U.S.-based health care plans as “buddies” or mentors to NIS-based organizations and tap the Internet as a cost-free means of communication.
2. Both the health economists and other professionals employed by Abt are a valuable resource for ensuring the project’s continued effectiveness. Some way should be found to continue their employment to help provide ongoing assistance to the recipients in Siberia and in Kaluga and Tver oblasts. Their local and U.S. contacts are a valuable source of continuing information; it would be a waste to let them disband.
3. The historical and obvious rivalries and frictions among all project participants as related in the management, design, and implementation of the ZdravReform program reflect poorly on the United States. All parties need to agree to clear lines of responsibility before any new work proceeds.

4. Failure to identify continuous and consistent management leadership for on-site operations in Russia detracted from the project. The turnover of senior management, failure to obtain individual long-term commitments, and inability to check backgrounds and capabilities adequately send the wrong organization management message to Russian partners.

C. Clinical Issues

1. The Manual of Clinical Quality Improvement prepared by Stanley Tillinghast, September 1996, is a superb document. In addition to putting it on CD-ROM, it should be fully translated, printed, and distributed selectively to students and faculty of medical schools, faculty of public health institutions, and members of health committees. It is a high-quality document that captures the *sine qua non* of health care reform from an analytic, clinical, and epidemiological perspective.
2. Physicians have assumed leadership roles in ZdravReform. They should be introduced to the American College of Physician Executives so that they can continuously develop and hone administrative and management skills. In addition, access to the rapidly changing principles and ethics of managed care will be necessary.
3. Tula Municipal Hospital #1 needs training of family physicians. The new project should facilitate the Tula link with the Canadian College of Family Physicians, the United Kingdom's Royal College of General Practitioners, and/or the American Academy of Family Physicians.

D. Information Management

1. The pilot sites are only now implementing their respective experiments. In terms of computers, the effective use of the new equipment and programs will require a long learning process at many of the sites. Most sites will make the common mistake of "computerizing" their existing work flow. If new project resources become available, USAID should fund technical assistance to help sites understand better how to reengineer work flow to optimize computer potential. They need to learn first how to determine organizational goals and then organize around them.
2. USAID should consider providing assistance with the development of a self-sustaining Russian Internet Web site to promote information flow and facilitate the dissemination of reform ideas. Assisting with provision of Internet access alone is not enough. The problem is that most of the health care community in Russia cannot speak English, thus limiting the current utility of the Internet even to those with access. The telecommunications infrastructure is another problem, one probably beyond the competence and funding capability of USAID. However, certain problems, such as the lack of Internet access servers outside Moscow, are well within USAID's purview.

3. The CD-ROM project as a vehicle for countrywide information dissemination is limited by insufficient access to information among those in need of information. Data from physician-oriented CME programs in the United States show that, at this time, the vast majority of U.S. physicians do not have access to CD-ROMs and that those with access do not use CD-ROMs for self-education unless interactive elements are included. If CD-ROM capability is linked to computer terminals used for other database activities, such as quality assurance, financial retrieval, and data analysis, the computer system will not be available for casual access and use for instructional purposes.
4. Continuous and long-term access to modern information will be critical to the success of health care reform. The CD-ROM project does not provide enough substantial help. The support of other forms of continuing education and interchanges are necessary.
5. The current plan that calls for Kaiser Permanente to distribute ZdravReform project products should be reexamined. Abt, perhaps as a subcontractor to Kaiser Permanente, should assume responsibility for product distribution. This is not a comment about the professional skills or integrity of Kaiser Permanente; it is merely recognition that it seems unreasonable to expect a new vendor to promote the work of a predecessor.

ANNEX E

LIST OF PERSONS CONTACTED—CENTRAL ASIA

ALMATY, KAZAKSTAN

Abdullin, Kellesbek, Dr.
Director, Pharmacy Department
Ministry of Health
Republic of Kazakstan

Aitmagambetova, Indira, MD
Project Management Specialist
USAID/Almaty
Office of Social Transition

Akanov, Akian, MD, Professor
Cardiologist
Deputy Minister for Social Sphere
Cabinet of Ministers
Republic of Kazakstan

Akhmetova, Karima F.
Head, Foreign Relations Board
Mandatory Health Insurance Fund
Republic of Kazakstan

Almagambetova, Naila
Medical Specialist
ZdravReform/Almaty

Borowitz, Michael, MD, PhD, MPH
Director
ZdravReform/Almaty

Buckles, Patricia
Mission Director
USAID/Almaty

Cheema, Jatinder, MPH, PhD
USAID/Almaty
Office of Social Transition

O'Dougherty, Sheila

Elliott, Don
Senior Consultant, Pharmacy Sector
International Executive Service Corps

Gursky, Viktor
Director, Romat Pharmaceutical Company

Haffner, Grace
Pharmaceutical Consultant
ZdravReform/Almaty

Imanbayev, Talapker T.
Director General
Mandatory Health Insurance Fund
Republic of Kazakstan

Krakoff, Charles
Pharmacy Specialist
ZdravReform/Almaty

Kulzhanov, Maksut, MD
Deputy Minister, Ministry of Health
Republic of Kazakstan

McGinnis, James S.
Franchising/Marketing Consultant
SOMARC Project
Vice President, Training and Development
Sizzler International, Inc.

Nurgozhin, Talgat
Abt Pharmacy Consultant
Clinical Information
ZdravReform/Almaty

Nugmanova, Damila
Abt Pharmacy Consultant, Clinical
ZdravReform/Almaty

DZHEZKASGAN, KAZAKSTAN

Deputy Director
ZdravReform/Almaty

Pennick, Norman
Abt Pharmacy Benefits Consultant
ZdravReform/Almaty

Ruschman, Don A.
Regional Manager, Central Asia Republics
SOMARC Project/The Futures Group

Rustemouna, Rosa
Chief Pharmacist
Almaty Pediatric Hospital

Sakenova, Zhanna, MD
Chief Physician
Almaty Pediatric Hospital

Samishkin, Evgenii
MIS Specialist
ZdravReform/Almaty

Schmakov, Viktor
Director, SibPharm

Slaski, Rafal
Financial Management/Grants
ZdravReform/Almaty

Zhurgenov, Aidarbek K.
Deputy Director General
Mandatory Health Insurance Fund
Republic of Kazakhstan

Tarasova, Lubov V.
Deputy Head
Mandatory Health Insurance Fund

Abzalova, Rosa A.
Zhourek Private Cardiac Care Center

Almenbetov, Bolat, MD
Director
City Family Practice Association

Begaliev, Torekhan
Director
Farmatsiya
Dzezkasgan Oblast

Domme, Alexandr
Director
“PAL” Company
Dzezkasgan Oblast

Korganbekova, Tuken
Chief, Financial Department
Mandatory Health Insurance Fund
Dzezkasgan Oblast

Makenbaeva, Alma, MD
Chief Internist, Oblast Health Department
Director, Oblast Family Practice
Association
Grantee

Rakhymbekov, Tolebai, MD
Director, Oblast Health Department
Dzezkasgan Oblast

Sidorenko, Evgenii
Computer Specialist
Mandatory Health Insurance Fund
Dzezkasgan Oblast

Skolkina, Larisa
Head, Computer Department
Mandatory Health Insurance Fund
Dzezkasgan Oblast

Beseynbayeva, Umutzhamal
Deputy Head Doctor for Medical Issues
Central Rayon Hospital

Dzezkasgan Oblast

Tazhikenova, Zhamal
Deputy Head
Oblast Health Department

Tillman, Victor, MD
Tillman Private Family Practice
Ambulatory Center

Zhagiparov, Murat
Director
Mandatory Health Insurance Fund
Dzezkasgan Oblast

Zhylispaeva, Akmaral
Mandatory Health Insurance Fund
Dzezkasgan Oblast

SEMIPALATINSK, KAZAKSTAN

Abdulina, Raisa
Head, Department of Quality Assurance
Mandatory Health Insurance Fund
Semipalatinsk Oblast

Abt, Ivan, MD
Head Doctor, Zenkovka SUB (Rural
Hospital)
Grantee, Association of Rural Family
Practitioners
Borodylikh Rayon

Baikunurova, Laura, MD
Family Group Practice Physician
(Therapist)
City Micropolyclinic
Semipalatinsk Oblast

Rublova, Nadezhda
Head, Marketing and Public Relations
Department

Borodulikh Rayon

Gubanova, Olga V.
Head, Department of Finance and
Economics
Mandatory Health Insurance Fund
Semipalatinsk Oblast

Imankulov, Yesengeldy, MD
Deputy Head, City Micropolyclinic
Semipalatinsk Oblast

Moldasheva, Maira, MD
Head Doctor
Nikolayevka SVA (Rural Physician
Ambulatory Facility)
Borodulikh Rayon

Musalimov, Yesen, MD
Deputy Head Doctor for Medical Issues
Central Oblast Hospital
Semipalatinsk Oblast

Orazgalieva, Marina, RPh
Director
Mandatory Health Insurance Fund
Semipalatinsk Oblast

Raikhanov, Serik, MD
Head Doctor, Central Rayon Hospital
Borodulikh Rayon

Raikhimbayeva, Gulnara
Deputy Head Doctor for Polyclinic
Central Rayon Hospital
Borodulikh Rayon

Rakishev, Turabek A., PhD
President
Romat Pharmaceutical Company
Semipalatinsk

Altymysheva, Gulbara, MD
Pediatrician
TyupRayon Family Group Practice,
“Santazh”

Mandatory Health Insurance Fund
Semipalatinsk Oblast

Samokhin, Gennady
Computer Specialist
Oblast Health Department
Semipalatinsk Oblast

Shkoda, Zoya Nikolaevna
Deputy Rayon Akim
Head of Social Sphere
Borodylikh Rayon

Zenulayev, Xhamit
Deputy Director
Mandatory Health Insurance Fund
Semipalatinsk Oblast

Zuss, Olga V.
Chief Financial Officer
Oblast Health Department
Semipalatinsk Oblast

KARAKOL, KYRGYZ REPUBLIC

Aidenova, Sulima
Family Practice Manager
Director
Rural Family Group Practice Association

Aitkulieva, Anara, MD
Head Specialist of Pediatrics
Oblast Health Department

Akmatov, Bakyt
Karakol Marketing Group

Maanaev, Toktobai
Head
Ak-suu Rayon Health System

Mahoney, Kenneth

Asherakmanova, Gulmira, MD
Director
Urban Family Group Practice Association

Bekturovna, Anna, MD
Head Specialist of Surgery
Oblast Health Department

Chynybaev, Sadir
Head, Rayon Health System
Dzety-Oguz Rayon
Issyk-kul Oblast

FGP Family Practice Managers
group of 20

Gerrish, Bradley, MD
Abt Consultant/STLI

Ibragimov, Alisher
Karakol Marketing Group

Imanbekov, Tilek
Deputy Head, Finance Department
Issyk-kul Oblast Administration

Ismailova, Tokon
Computer Expert
Oblast Health Department

Ketsetzulu, Bakyt
Family Practice Manager
Tyup Rayon

Krainilov, Ivan
Computer Expert
Oblast Health Department

Subanova, MD
Marketing Campaign
Dzergalan Village, Issyk-kul Oblast

Turgunbayeva, Djamagul, MD
Chief of Internal Medicine

Director
RTI Municipal Financing Project in
Karakol (USAID)

Millslagle, Dean
IDS Manager/Training and Development
ZdravReform/Karakol

Mombekova, Shaken, MD
Deputy Director
Tyup Rayon Central Hospital
Issyk-kul Oblast

Mukanova, Nuripa
Office Manager
ZdravReform/Karakol

Rommen, Idar, MD
Abt Consultant/STLI

Ryspaev, Kojubil
Deputy Head, Oblast Health Department
Issyk-kul Oblast

Saalieva, Damira M.
Director, Oblast Health Department
Issyk-kul Oblast
Director, Kassa-Zdorovya

Sokolova, Elena
Computer Expert
Oblast Health Department

Sturova, Elena
Karakol Marketing Group

Polyclinic
Dzety-Oguz Rayon

Ujkhta, Oksana
Computer Expert
Oblast Health Department

ANNEX F

LIST OF PERSONS CONTACTED—UKRAINE

KYIV

Alpatov, Anatoliy
Head, Department of Medical
Cybernetics
Dnepropetrovsk Medical Academy
Dnepropetrovsk Oblast

Bazylevich, Jaroslav
Head, Public Health
Management Unit
Lviv Medical Institute

Bolukh, Sergei
Head, Family Medicine Department
Ukraine Ministry of Health

Kartysh, Anatoliy
Deputy Minister
Ukraine Ministry of Health

Kolodenko, Vladimir, MD, PhD
Director
Institute of Health Care Management
and Development
Odessa State Medical University

Lehan, Valeriya, MD
Dnepropetrovsk Medical Academy

Makinen, Marty
Acting Director
ZdravReform/Kyiv

Morozov, Anatoliy
Head, Main Department of Adult
Medical Care
Ukraine Ministry of Health

Telyukov, Alexander
Health Financing Expert (visiting)
ZdravReform/Bethesda

Wouters, AnneMarie

Mostipan, Oleksandr, MD
Chief Physician
Family Medicine Polyclinic
Dneprodzerdzhinsk City
Dnepropetrovsk Oblast

Omelchenko, Ludmilla, MD
Medical and Data Expert
ZdravReform/Kyiv

Omelchenko, Victor, MD
Licensing and Accreditation Expert
ZdravReform/Kyiv

Ponos, Roman
Office Manager
ZdravReform/Kyiv

Prodanchuk, Mikola
Director
National Institute of Health
Kyiv

Rudiy, Volodimir
Chief of Secretariat
Commission of Child and Motherhood
Protection
Supreme Rada of Ukraine

Solonenko, Ivan
Director
School of Public Health Administration
Kyiv Medical University

Sytnik, Lydia, MD
Licensing and Accreditation
Ukraine Ministry of Health

Pavlovsky, Mikhailo, MD
Rector
Lviv Medical Institute
Chief of Faculty Surgery Department

Reeves, John, MD

Acting Deputy Director
ZdravReform/Kyiv

LVIV OBLAST

Bichenko, Svetlana
Deputy Head Doctor/Economist
Lviv City Hospital #1

Honcharova, Roma
Economist
Lviv City Hospital #1

Huzar, Z., MD
Head
Lviv City Health Administration

Jafarova, Jemma, MD
Head Doctor
Lviv City Hospital #1

Markhiv, E., MD
Head Doctor
Yavoriv Central Rayon Hospital

Martinyuk, Galina, MD
Head Doctor
Warshawska Family Ambulatory Clinic
Lviv City Hospital #1

Melnyk, Nadiya, MD
Deputy Director
Lviv Oblast Health Care Administration

Oliynik, Vadim, MD
Acting Director
Lviv City Polyclinic #2

ODESSA OBLAST

Antonenko, Anatoly, MD
Chief Doctor
Odessa Municipal Dental Clinic #6

NADIYA/Abt Family Medicine
Consultant
ZdravReform/Lviv

Schedriy, Petro, PhD
Director
TransMedStrakh—Ukrainian
Stockholding Company
Lviv Railroad Medical Insurance
Experiment

Sheremeteva, Taras, MD
Chief, Out-Patient Surgery Clinic
Lviv City Polyclinic #2

Stevens, John
IDS Director
ZdravReform/Lviv

Sudova, Lesya, MD
Chief Department of Family Medicine
Lviv City Polyclinic #2

Uspensky, Borys, MD
Medical Director
ZdravReform/Lviv

Veres, Victor, MD
Head Doctor
Zhovkva Central Rayon Hospital

Zaremba, E., MD
Chair
Family Medicine Department
Lviv Medical Institute

Zelinska, Alla
Economist
Lviv City Polyclinic #2

Lissvelt, Jennifer
Information Dissemination
ZdravReform/Odessa

Litvak, Akim, MD
Deputy Head

Astvatsatryan, Grogory, MD
Deputy Chief Doctor
Odessa Polyclinic

Babenko, Eshova, MD
Chair
Philosophy and Sociology
Odessa Medical University

Bespoyasnaya, Valentina, MD
General Director
Family Health Center

Borsch, Vitaly, MD
Chief Doctor
Kodyma Rayon Hospital
Odessa Oblast

Chernetsky, Veniamin, MD
Chief Doctor
Odessa City Hospital #10

Ivanov, Nikolai, MD
Director, Health Department
Odessa City Council of Deputies
Administration

Kolodenko, Vladimir, MD
Prorector
Odessa Medical University

Kuzmina, Nataly
Computer Programmer
Odessa City

Oblast Health Administration

Loseva, Vallida, MD
Deputy Head
Odessa Oblast Health Administration

Shubin, Anatoly, MD
Chief Doctor
Odessa City Polyclinic

Sknarina, Olga
Chief Accountant
Odessa Oblast Clinical Hospital

Wittenberg, Tom
IDS Director
ZdravReform/Odessa

ANNEX G

LIST OF PERSONS CONTACTED—RUSSIA

MOSCOW

Bobronnikov, Ellen
Grants Manager/Senior Analyst
ZdravReform/Russia
Abt Associates

Makarova, Tatiana, PhD
Senior Economist
ZdravReform/Russia
Abt Associates

Poer, Kathleen
Administrative/Finance Officer
ZdravReform/Russia
Abt Associates

Ragimova, Svetlana
Interpreter/Coordinator
ZdravReform/Russia
Abt Associates

Sheiman, Igor, PhD
Senior Economist
ZdravReform/Russia
Abt Associates

Solovyova, Julia
Assistant Grants Manager
ZdravReform/Russia
Abt Associates

Tsepalov, Nikolai
Software Engineer
Paragraph/Interface Company
Moscow

Omelchenko, Vladimir, MD

KALUGA OBLAST

Aksutenkov, Igor, MD
Chief Doctor
Fersikovo Rayon Hospital
Kaluga Oblast

Dokuchaev, Valery
Deputy Director
Finance
Hospital/Polyclinic #5
Kaluga City

Dolotyonkov, Lev
Head, Information Systems Department
Territorial Health Insurance Fund
Kaluga Oblast

Kondukov, Vladimir, MD
Municipal Health Care Administration
Kaluga City

Konratiev, Yuri
Chief Doctor
Pediatric Hospital
Kaluga

Kremlyova, Natalya
Head, Quality Assurance Department
Territorial Health Insurance Fund
Kaluga Oblast

Malyarov, Nikolai
Chief Doctor
Hospital/Polyclinic #5
Kaluga City

Vovkodav, Tatyana

Executive Director
Territorial Health Insurance Fund
Kaluga Oblast

Pavlovitch, Lev
Vice Director
Kaluga Territorial Health Insurance
Fund
Kaluga Oblast

Prokovo, Tatyana, MD
Deputy Chief Doctor for Economics
Fersikovo Rayon Hospital
Kaluga Oblast

Smirnov, Oleg, MD
Deputy Chief Doctor for Quality
Emergency Hospital
Kaluga City

Sumarokov, Vyacheslav
Chief Doctor
Emergency Hospital
Kaluga City

Vlasov, Alexandr
Chief Doctor
City Polyclinic #1 (Oktyabrskaya)
Kaluga City

Voronin, Sergei
Deputy Chair
Health Care Committee
Kaluga Oblast

Voronina, Tatyana
Quality Assurance
Hospital/Polyclinic #5
Kaluga City

Gaskova, Nina, MD
Chief Doctor for Medical Issues

Deputy Director
Territorial Health Insurance Fund
Kaluga Oblast

TULA OBLAST

Dubrovski, Michael
Albany Community Health Plan
Consultant for Albany–Tula Project
New York, New York

Fedorchenko, Boris
Executive Director
Tula Territorial Health Insurance Fund
Tula Oblast

Forneev, Alexander
Executive Director
Municipal Hospital/Polyclinic #1
Tula City

ALTAI KRAI

Borovik, Evgenii, MD
Chief Doctor
Gordeevo District Hospital
Altai Krai

Chernikov, Sergei
Coordinator
ZdravReform/Barnaul
Altai Krai

Dracheva, Tatyana, MD
Deputy Chief of Bureau of Licensing
and Quality Assurance
Altai Krai Health Care Committee

Ertel, Raissa
Group Leader, “MedProfilaktika”
Troitsk Rayon Hospital
Altai Krai

Nechayev, Valery, MD
Chief Doctor

Quality Assurance
Novoaltaisk Hospital
Altai Krai

Gnusova, Olga, MD
General Practice #10
Polyclinic #10
Barnaul City
Altai Krai

Kirichkov, Alexander, MD
Director
Altai Krai Health Care Committee

Kolpakova, Olga
Programmer
“MedProfilaktika”
Troitsk Rayon Hospital
Altai Krai

Korolyova, Irina, MD
Chief Therapist
Therapeutic Department
Troitsk Rayon Hospital
Altai Krai

Kulik, Yurii, MD
Chief of Economics
Altai Krai Health Care Committee

Litvinenko, Leonid, MD
Chief Doctor
Novoaltaisk Hospital
Altai Krai

Nechaeva, Raissa
Deputy Chief Doctor
Quality Assurance
Troitsk Rayon Hospital
Altai Krai

Banin, Sergei
Deputy Head
Oblast Health Department

Troitsk Rayon Hospital
Altai Krai

Pitchuk, Vladimir
Deputy Chief Doctor
Work with Subdivisions
Troitsk Rayon Hospital
Altai Krai

Shevchenko, Vera V., MD
Chief Doctor for Economics
Novoaltaisk Hospital
Altai Krai

Yegorova, Iya, MD
Chief of Bureau of Licensing and
Quality Assurance
Altai Krai Health Care Committee

Yelykomov, Valery, MD
Chief Therapist
Altai Krai Health Care Committee

Yemeshin, Konstantin, MD
Director
“MedProfilaktika”

TOMSK OBLAST

Alexandrova, Tatyana
Deputy Head
City Health Care Department
Tomsk City

Astanina, Tamara
Deputy Head
Oblast Health Care Department
Tomsk Oblast

Ivleva, M.
Chief Accountant
Polyclinic #10

Tomsk Oblast

Belykh, Svetlana
Coordinator
ZdravReform/Tomsk
Tomsk Oblast

Borodina, Anna, MD
Chief Doctor
City Polyclinic #10

Dombrovskaya, N., MD
General Practitioner
Polyclinic #10
Tomsk

Dubinina, Zinaida
Department of Finance
Tomsk Oblast Administration

Fedchenko, E., MD
General Practitioner
Polyclinic #10
Tomsk

Gabdrakhimova, Tatyana
Deputy Head for Economics
Health Care Department
Tomsk Oblast Administration

Goleva, Tamilla, MD
Director for Ambulatory Care
City Hospital #3
Tomsk City

Gorshenev, Victor, MD
Deputy Chief Doctor
Oblast Clinical Hospital
Tomsk Oblast

Linok, Igor
Deputy Executive Director
Tomsk Territorial Health Insurance Fund
Tomsk Oblast

Tomsk

Kachenko, N., MD
General Practitioner
Polyclinic #10
Tomsk

Khlynin, Sergei, MD
Senior Expert Quality Issues
Oblast Health Care Department
Tomsk

Khokhlov, Valery
Vice Governor for Social Issues
Tomsk Oblast

Kolosova, Irina, MD
Medical Director
City Hospital #3
Tomsk City

Kovryzhnykh, Vyacheslav, MD
Chief Doctor
City Hospital #3
Tomsk City

Kozlov, Victor
Deputy Executive Director
Tomsk Territorial Health Insurance Fund
Tomsk Oblast

Levenko, Yuri, MD
Head
Central Medical and Sanitary Unit
(City-level facility—Sanitary and
Epidemiological Service)

Pravoda, Vera
Deputy for Economics
Oblast Clinical Hospital
Tomsk Oblast

Makhletsova, Rosa
Hospital Economist
Oblast Clinical Hospital
Tomsk Oblast

Martyshevskaya, V.
Computer Programmer
Polyclinic #10
Tomsk

Monastyreva, Olga, MD
Medical Director
Group Practice
Polyclinic #10
Tomsk

Oleinichenko, Vladimir, MD
Chair of the Department
of Social Hygiene and Health Care
Organization
Siberian State Medical University
Tomsk

Peremitin, Gennady
Head of Health Care Department
Tomsk Oblast Administration

Petrova, Ludmila, MD
Chief Doctor
City Polyclinic #1

Petrova, Ludmila
Head
Medical Statistics Center
Tomsk Oblast Health Department

Andreeva, M., MD
Head
Medical and Preventive Care
Department
Kemerovo Insurance Company

Serykh, Boris T., MD
Chief Doctor
Oblast Clinical Hospital
Tomsk Oblast

Solovtsov, Anatoly, MD
Deputy Chief Doctor
Oblast Clinical Hospital
Tomsk Oblast

Tusnova, M.
Deputy for Economic Issues
Polyclinic #10
Tomsk

Tzvinger, Nadezhda
Department of Finance
Tomsk Oblast Administration

Vendrov, Zinovii
Director
Tomsk Oblast Information Center
Oblast Health Care Department

Zozulia, Valery
Director
Seversky Branch (Filial)
Territorial Health Insurance Fund
Tomsk Oblast

KEMEROVO OBLAST

Akhmerov, Rashid, MD
Chief Doctor
Polyclinic #12
Kemerovo City

Krasnova, Nelli
Deputy Executive Director
MHI Territorial Fund

Kurakina, Elena

Babarykina, Svetlana
Head
Territorial MHI Fund
ZdravReform/Coordinator

Chizhov, Boris
Deputy Director
Kemerovo Medical Center

Dremina, Larissa, MD
Deputy Chief Doctor
Polyclinic #12
Kemerovo City

Fyodorova, Irina
Deputy Head
Oblast Administration on Social Issues
Kemerovo Oblast Administration

Golubev, S.
Head
Methodology Department
Kemerovo Insurance Company

Isakova, Lyudmila
Director
SibForms Fund

Khodakova, Natalya
Director for Economic Issues
City Health Department
Polyclinic #12

Kochemasova, Olga, MD
Chief Doctor
Medical and Sanitary Unit #17
Kemerovo Oblast

Sedacheva, Lyudmila, MD
Deputy Chief Doctor
Ambulatory Care
General Practice
Polyclinic #5

Director for Information Systems
Kemerovo Insurance Company

Leontieva, Veronika, MD
Medical Director
City Insurance Fund
(Bolnichnaya Kassa)

Lokhmatko, Galinia
Chief Doctor
Oblast Dentist Clinic

Mikhailova, Vera
Deputy for Economics
Oblast Dentist Clinic

Nelepina, Natalya
General Director
Kemerovo Insurance Company

Nesteriuk, Mikhail
Head Engineer
Kemerovo Information Center

Petrenko, Anna, MD
Chief Doctor
Tissul Central Hospital
Kemerovo Oblast

Poteeva, L.
Chief Accountant
SibForms Fund

Prokudina, N., MD
Chief Doctor
Medical and Sanitary Unit #15
Kemerovo Oblast

Fomin, Grigory, MD
Medical Director
Oblast Hospital

Ilyins, Vera, MD
Chief

Tarasov, Nikolai, MD
Head
Myocardial Infarction Department
Cardiology Center

Temerkhanova, Larissa, MD
Chief Doctor
General Practice
Polyclinic #5

Zakirov, Anvar
Head
City Insurance Fund “Kemerovo”
Oblast Health Department

Zelkovich, Roman
Director
Kemerovo Information Center

NOVOSIBIRSK OBLAST

Bochanov, Evgenii
Chief of Bacteriological Laboratory
Immunological Institute

Bychkov, Alexander
Chair
Health Care Committee
Novosibirsk Oblast

Domnikova, Natalya, MD
Medical University Assistant
Quality Issues
Oblast Hospital

Bacteriological Laboratory
Oblast Clinical Hospital

Ivaninskaya, Alla
Director
ASOPO Zhizn Insurance Company
Novosibirsk

Melnikov, Mikhail, MD
Deputy for Medical Issues
Health Care Committee
Novosibirsk Oblast

Nagornaya, Irina, MD
Medical Director
Municipal Hospital

Oshepkova, Ludmila, MD
Chief Epidemiologist
Oblast Hospital

Rogov, Vladimir
First Deputy
Health Care Committee
Novosibirsk Oblast

Zorina, Marina, MD
Epidemiologist
Oblast Hospital

ANNEX H

EVALUATION TEAM MEMBERS

Team Leader

George A. Laudato
Deputy Assistant Administrator, Retired
Bureau for Asia and Near East
United States Agency for International Development

Team Members

Larry Barenbaum, RPh
President
RX IMAGE, INC.

Harris A. Berman, MD, FACP
President and Chief Executive Officer
Tufts Associated Health Plans

Christopher Bladen
Acting Deputy Assistant Secretary for Health Policy, Retired
Office of the Assistant Secretary for Planning Evaluation
United States Department of Health and Human Services

John M. Merenna
President
JV SOLUTIONS

Clydette L. Powell, MD, MPH
Associate Medical Director, Quality Improvement
Health First Medical Group

Anthony F. Vuturo, MD, MPH
Senior Partner
VSF INTERNATIONAL, LTD

Robert S. Wilkinson
Executive Vice President
Health Services Medical Corporation of Central New York, Inc.

David L. Woodrum
President
Woodrum, Inc.

ANNEX I

**EVALUATION OF THE HEALTH CARE
FINANCING AND SERVICE DELIVERY
REFORM PROGRAM IMPLEMENTED
BY ABT ASSOCIATES, INC.
(CCN-0004-C-00-4023-00)**

PHASE I

July 16, 1996

Submitted to USAID/W ENI/HR/HP
under
USAID/ENI/HR Technical Assistance Project
(Contract No. DHR-0037-C-00-5067-00;
Task Order 96-0007)

By
Robert W. Beckman, Team Leader
Robert S. Wilkinson
David L. Woodrum

USAID/ENI/HR Technical Assistance Project
BHM International, Inc.
1800 North Kent Street, Suite 1060
Arlington, VA 22209

The observations, conclusions, and recommendations set forth in this document are those of the authors alone and do not represent the views or opinions of the USAID/ENI/HR Technical Assistance Project, BHM International, Inc., or the staffs of these organizations.

TABLE OF CONTENTS TO PHASE I REPORT

	<u>PAGE</u>
INTRODUCTION	I-5
I. UKRAINE	I-7
A. GENERIC QUESTIONS (FOR BOTH USAID MISSION AND ABT/Kyiv)	I-7
B. QUESTIONS FOR THE USAID MISSION	I-13
C. QUESTIONS FOR USAID AND ABT REGARDING THE NEXT PHASE OF THE EVALUATION	I-16
D. GROUP DYNAMICS	I-17
II. RUSSIA	I-19
A. GENERIC QUESTIONS (FOR BOTH USAID MISSION AND ABT/MOSCOW)	I-19
B. QUESTIONS FOR USAID/MOSCOW	I-25
C. QUESTIONS FOR USAID AND ABT REGARDING THE NEXT PHASE OF THE EVALUATION	I-31
D. GROUP DYNAMICS	I-32
ANNEXES	
ANNEX A: CLELAND/PIELEMEIER LETTER OF MAY 10, 1996	
ANNEX B: SCOPE OF WORK	
ANNEX C: INTERVIEW GUIDE	
ANNEX D: LIST OF PEOPLE INTERVIEWED (UKRAINE)	
ANNEX E: MEASURING PROGRESS: IMPACT INDICATOR TARGETS	
ANNEX F: ZDRAVREFORM UKRAINE PRODUCTS LIST AS OF MAY 10, 1996	
ANNEX G: SUGGESTED INTERVIEWS FOR EVALUATION PHASE II (UKRAINE)	
ANNEX H: ZDRAVREFORM PRODUCT STATUS CHART AS OF MAY 16, 1996	
ANNEX I: PROJECT RESULTS ACCORDING TO ABT	
ANNEX J: ZDRAVREFORM PROGRAM BRIEF CHRONOLOGY—1/94-5/96	
ANNEX K: LIST OF PEOPLE INTERVIEWED (RUSSIA)	
ANNEX L: USAID STRATEGIC OBJECTIVE 3.2	
ANNEX M: EXAMPLES OF ACTIVITIES (CLINICAL PATIENT RECORD SYSTEM, TERRITORIAL INSURANCE FUND SYSTEM)	
ANNEX N: SUGGESTED INTERVIEWS FOR EVALUATION PHASE II (RUSSIA)	
ANNEX O: ZDRAVREFORM SITE MAP; ABT BRIEFING BOOK (NOT ATTACHED)	
ANNEX P: LISTING OF ABT/RUSSIA GRANTS	
ANNEX Q: RUSSIA ZDRAVREFORM OUTPUT AREAS AND SITE PROFILES	

[THIS PAGE INTENTIONALLY LEFT BLANK]

INTRODUCTION

USAID/ENI/HR is planning an evaluation of the ZdravReform project in the former Soviet Union, with the main field work scheduled for September and October 1996.

Four key staff are shortly leaving the project. In Ukraine, they are Abt Chief of Party (COP) Marc Stone and USAID Personal Services Contractor (PSC) Health Officer Nicole Simmons. In Russia, they are Abt COP James Rice and USAID PSC Senior Health Advisor Susan Cheney. USAID/ENI/HR requested that an advance team capture the institutional memory of these key players to the degree possible in a snapshot. This picture includes getting a sense of the group dynamic of the players, teams, and interactions with one another. Another objective of the visit was to lay the groundwork for the fall site visits. (See scopes of work for the advance team in Annexes A and B.)

Methodology. The team conducted interviews in accordance with an interview guide (see Annex C). The team met with both USAID and Abt representatives (lists of persons interviewed are provided in Annexes D and K) at their offices and in the informal setting of homes and local restaurants.

[THIS PAGE INTENTIONALLY LEFT BLANK]

I. UKRAINE

A. Generic Questions (for both USAID Mission and Abt/Kyiv)

1. Was the conceptual framework right (i.e., pick local areas with champions, then pour in technical help)?

USAID. Yes, but ideally the USAID Mission rather than Abt should have selected the projects. The country is not stable enough for long-term planning, particularly as evidenced by high inflation and austerity budgeting. Each oblast (state) has seen significant reductions in financial resources and, in turn, has reduced allocations to health institutions. In addition, five ministers of health have been appointed since the health officer's tenure began in October 1994. Therefore, an initial national focus on health care reform was probably not possible. The local initiatives were allowed to develop and are now ready for presentation for national consideration.

The two main projects in Odessa and Lviv take markedly different approaches that reflect the country's diversity and suggest that a single solution to health care reform may not be possible or desirable. The health care system in place in Lviv is integrated at all levels, whereas the system in Odessa is more entrepreneurial in nature. In both locations, oblast politics plays a part in the success of the projects. Odessa has been a problem site because of political conflict between the mayor of Odessa and the governor of the oblast.

Site selection for intensive demonstration site (IDS) interventions was based on which local counterpart responded first and most favorably. Other possible sites, such as in eastern Ukraine, would have resulted in a different focus for an IDS (i.e., medical informatics).

The technical help offered initially was not as helpful as the more recent assistance. It did not build skill for the Abt Russian staffs and lacked the continuity necessary to build trust.

Local resources should have been used more. "All you need is a good Chief of Party (COP) and then hire local staff to help the project counterparts." Too much was spent on short-term temporary duty U.S. consultants who did not maintain the continuity necessary to build trust with the counterparts. At the same time, the back office costs did not add enough value. In general, the central office add-on costs were *not* perceived as too high (7 percent), but extras beyond the 7 percent were hard to justify. Local personnel costs are extremely low (i.e., the cost of one computer could pay 30 local staff salaries for one month).

Abt. Ukraine was not a good candidate for health care reform at the national level because of the instability of the MOH and inconsistency in policy direction. Ukraine is, however, a good prospect for local initiatives. (In contrast, the Central Asia project is a good setting for national policy reform because of stable, reform-oriented MOH policy.) USAID needs to develop a plan to respond if Ukrainian national policy turns to reform after the termination of the Abt contract.

Ukraine lacks a comprehensive national health policy, which gives rise to a single dominant question: What is possible to implement in the way of reforms, beginning at the local (regional) level? The Ministry of Health at first resisted the IDS concept but now sees its value. The focus of the project will now shift increasingly to the MOH. “Trickling up” of IDS examples to the MOH is occurring. Lviv and Odessa turned out to be extremes, but their outcomes are valid.

At this time, no single model of dissemination is being promoted. “Roundtable” dialogues are being planned to explore the merits of the local projects. As a result, momentum is building.

Abt had to deal with three different ideas regarding the contract from the three NIS Missions. Not surprisingly, Abt experienced difficulty in administering the contract and was unable to achieve synergism in administration. Originally, Abt operated on the basis of a single funding source but had to switch to three financial systems after the contract was signed.

**2. Did they hit the right targets in terms of institution building (hospitals, polyclinics, insurance)?
What were the main targets?**

USAID. The institution-building focus was questionable in some rayons (counties), especially the remote rural rayon in Lviv oblast. However, overall financial management succeeded and was an appropriate target. As a technical assistance agent, Abt could have more effectively fulfilled the liaison role between the MOH and the local level. The interface with the MOH required greater attention; instead, Abt’s focus on institutions was too concentrated.

Regions low on basic resources should have received a higher level of attention. “They are closing wounds with glue, people are making five-hour trips to see a feldsher (paramedic), access is a problem.” Computer acquisition was not contemplated and could add value if spreadsheet software was available to local Abt Russian staffs.

Abt. Lviv is clearly making progress (for example, three hospitals have closed). Family practice curriculum development occurred in Lviv beyond the contract specifications. It is less clear how the Odessa project will bring forward national applications. (Odessa differs sharply from other areas of Ukraine.) Dnipropetrovsk could have been an appropriate project as it has good medical informatics and a capable physician who could champion reform.

3. Were the processes effective in achieving the goals within the conceptual framework (grants, training, information dissemination, finance and administration, regional programs)?

- C Is the in-place cost-accounting system effective?
- C Is it permitting you to identify cost and task sufficiently?

- C What is the cost of the specific reforms we are trying to promote (i.e., moving care from hospital to clinics)?
- C Did the cost-accounting system facilitate communications when objectives or budgets changed?
- C How did small grant programs support the idea of health care reform?

USAID. It took too long to define the processes and gain consensus on them. *The best work occurred in the financial management training process. The least effective involved local counterpart development*, which is difficult but necessary for the long-term success of reform by the country.

The small grants program was not used in Ukraine because the health officer judged that the procedures were too management-intensive for the relatively small project staff. Furthermore, implementation of the grants program would have detracted from the core TA effort.

The medical school partnership program administered by IREX as a separate contract offers a potential intervention point for carrying on the reform process once the Abt contract ends in December 1996.

The USAID health officer has not followed the cost-accounting function but recognizes that Abt has performed such work and believes the organization has the ability to track “product” costs.

Abt. Abt confirmed that the technical assistance “price tag” for specific products is known. The local cost of implementing reform is usually financially negative (i.e., the reform saves the system money), but most reform faces a social policy hurdle in the form of displaced labor. In both the historic context of a full employment policy—with severe penalties for absenteeism—and the current context of massive disguised under- and unemployment, labor-saving reforms are extremely difficult to implement.

Abt/Kyiv pointed out that the Task Order (TO) process has turned into a budgeting, expenditure control, and dereservation nightmare because of the requirement for four signatures for the original TO and any modifications. Dereservations of unexpended funds are not automatic. The TO system provides a high level of control for USAID but unduly constrains Abt, preventing the organization from making rapid adjustments in response to targets of opportunity. (Abt/Bethesda felt that the TO system facilitated communications with USAID and helped overcome the deficiencies in the broad general contract.)

Abt noted the periodic emergence of a stumbling block. The organization would gear up for a specific activity with personnel, local counterparts, and other resources only to discover that changing USAID or congressional priorities and funding forced termination of the activity, which resulted in loss of valuable people, contacts, and resources.

In Ukraine, the requirement for a medical doctor COP limited the number of potential candidates. Therefore, Abt was slow in filling the COP position with a qualified person.

The time available to accomplish the contract tasks may not be sufficient given the decision to start late in Ukraine.

The notion of the national roundtables is untested, although early results reveal that the roundtables have assisted in terms of education and communications.

The Lviv site manager worked in Slovakia at Trnava and Bankska Bastricia. The experience gained in Slovakia in implementing quality assurance programs at the local level had applicability to the work in Lviv. The Ukraine program has definitely benefited from the Eastern Europe learning curve.

Both USAID and Abt implied that the processes selected to support the IDS interventions were appropriate.

- 4. Considering that reform comes in incremental advances, will the project meet its objectives?
Do the projects have promise?
What reforms have been most effective?**

USAID. The project will achieve significant impact, particularly in the financial management of health care facilities. First, the MOH is interested in anything that will close hospital beds (despite the labor problem). Second, the MOH is exploring per capita financing issues. Assuming no major change in MOH direction, these trends will be sustained.

The MOH situation, however, requires some qualification to the above paragraph. Turnover of ministers of health is a problem; indeed, the most recent past minister and the current minister are “at war” while the local counterparts are frustrated by the MOH. (The system was described as a command model, with national decrees for reform.) Therefore, without MOH endorsement, reforms cannot advance unless further alignment is forthcoming at the national level. Additional work is necessary to allow reform to progress through the political process in Kyiv. Abt staff were not effective in this area.

USAID’s impact indicator targets (see Annex E) will likely be met, although a question remains as to whether Abt is measuring progress.

Abt. Yes, there is potential for impact despite the policy vacuum, in-fighting, and turnover. The best strategy is to find out what can be done and to do it. Lviv and Odessa are extremes. The former is a connected community in health care and has developed a unitary model. Odessa is more free-wheeling and is pursuing a free market model.

The project is organized around a sequential process from concept to implementation. Counterpart development has only recently begun in the Ukraine project due to late startup.

With the contract coming to an end, another mechanism must be developed to ensure the successful conclusion of the reform aspects of the project.

Cross-fertilization between regional projects has occurred only in the last six months of the project. The split of the original project has exacerbated the delay in communication.

That the MOH is under pressure to reduce the number of hospital beds provides a favorable context for the project. Nonetheless, the project can point to measurable and attributable success in promoting hospital bed reduction in the IDS areas. For example, the project has helped local administrators prepare contingency plans that were deployed in response to budget cuts. The plans provided local officials with the political cover they needed to issue the specific directives required to accomplish the changes.

The strong consensus on the need to reduce the number of hospital beds will lead to adoption of a national policy in favor of facilities rationalization and more efficient use of the health care budget.

Five areas of potential national impact arise from the interventions that underwent testing in Lviv and Odessa (see Annex F).

a. **Financial Management.** The health care system is in desperate need of revenue. Many administrators are familiar with and ready to adopt user fees and self-financing options. Before such systems can be implemented, however, administrators must know how much to charge for services. The ability to understand how to assess and charge fees is empowering for administrators whose entire experience is limited to command and control structures. The project can and is willing to show administrators how to perform the needed analysis and record keeping.

b. **Family Medicine.** Shifting the main burden from specialists to family-oriented, primary care physicians is a fundamental requirement for saving money. A three-year residence in family medicine has now been started at Lviv medical school. Family medicine may become the topic for the first national roundtable planned under the project.

c. **Alternative Use of Facilities.** Closing facilities is politically unpopular for local administrators, who must assume accountability. The project has generated examples of how to close facilities, namely, by transforming facilities and reallocating staff to new functions.

d. **Clinical Pathway or Clinical Protocol Development.** Pathway or protocol development is not new, but the format is different in the context of the former Soviet Union. Protocols have been worked out. Their widespread use would save significant amounts of money and points to facilities rationalization.

e. **Certification.** The MOH uses certification to encompass licensing and accreditation. Ukraine may draw on a model Abt developed for the Kyrgyz Republic. Abt will pursue certification if the MOH signals strong interest.

In sum, the project is ready to move in all of these areas. Materials based on the IDS interventions are available in Russian. Key MOH personnel have been identified and cultivated. The national roundtable concept has been organized to provide a high-level forum for dialogue among decision-making authorities.

5. Cross-Cutting Issues

Abt believes that the issue of how project materials from the three regions (Russia, West NIS, and Central Asia) are **shared, preserved, and disseminated** needs to be addressed in order to achieve the full impact of the ZdravReform technical assistance effort. (Langenbrunner and Makinen would be the best people to pull together products into a single report.)

Abt/Kyiv is prepared to distribute “how to” manuals, narratives on health care reform initiatives, and curricula development materials (see Annexes F and H). The production and dissemination of information is planned as the responsibility of counterparts and stands in contrast to implementation by U.S.-based companies. Abt’s concept is to sign a memorandum of understanding with a counterpart organization (e.g., programs in hospital administration) as the repository of information. Abt envisions an electronic form of publication.

Russia deemphasized technical assistance from the United States, whereas Ukraine and CAR used American technical assistance to a greater degree. In Ukraine, Abt subcontractors and counterparts performed technical assistance work. In Russia, local counterparts performed the large share of the work with less reliance on American short-term temporary duty consultants. The variation in approach presented Abt with administrative problems.

U.S.-based short-term consultants performed most training activities. In Russia, the resident technical experts were the primary resource for training. In both Russia and Ukraine, customer satisfaction surveys followed the delivery of educational programs. According to Abt, the results revealed that the programs were “highly rated.” A side benefit to the training was the counterpart’s enhanced receptivity to change.

B. Questions for the USAID Mission

1. How is the Mission organized?

The ZdravReform project was managed by USPSC Health Officer Nicole Simmons (EDD June 7, 1996; Michelle Varnhagen will be the replacement). The health officer works in the Office of Social and Democratic Transition, one of three Mission technical offices. The office director is Roger Yochelson. The office covers democracy, environment, health, and social protection.

2. What are the Mission's strategic objectives?

Pertinent strategic objectives are measured by impact indicators associated with the project (see Annex E).

3. What and why course corrections?

There have been no significant course corrections to the W/NIS program since it became operational.

4. What other issues affect the work of the Mission?

Abt is also the Mission's Global Bureau health sector contractor. Hence, the Mission is facing a *de facto* sole-source procurement for technical assistance resources in health care reform.

In response to pressures from the State Coordinator for the NIS (Richard Morningstar) and congressional staff, the Mission has stated repeatedly that the Abt contract will not be extended in W/NIS with Mission budget allocations. However, the Mission remains interested in health sector reform and may pursue its interest beyond December 1996 with other funds/mechanisms, e.g., the hospital partnership program in which Abt-generated materials may be used.

The ZdravReform project and the Abt contract have been administered as if they were three separate contracts. In consequence, the health officer felt that she was competing with Moscow, Almaty, and Abt headquarters staff for resources and management attention.

In general, Abt performed poorly in adapting its management approach to the W/NIS region once it was decided to implement the ZdravReform project. Examples of this pattern follow:

- C Failure to identify staff in advance of the startup in Ukraine. Abt knew that the project would start, even though it was delayed. Hence, the organization should have made candidates available. The Mission health officer had to run the project for eight months in the absence of a COP. The outgoing COP, Dr. Marc Stone (EDD May 31, 1996), who has been with the project for about 14 months, will not be replaced; instead, Abt

proposed that the COP function be handled on a rotating basis between Abt/Bethesda staff Annemarie Wouters and Marty Makinen. This approach is questionable but acceptable because of the short time remaining in the contract.

- C Abt expects the health officer to help screen candidates instead of presenting fully screened candidates for approval. A particular concern is that Abt does not seem to understand what qualities to look for in a COP.
- C Abt backstopping of the field team has been “atrocious.” Abt has failed to follow up on repeated requests for information from Bethesda; the librarian there seems to be focused exclusively on the project newsletter.
- C Abt has not performed a planned operations research task under the work plan.

5. Was the contract well designed?

The contract was too broad, and regional contracts “don’t work.” Consortia of firms, as is the case with this contract, “don’t work.” The contract reflected the project authorization’s lack of specificity about project details. In practice, however, the management of the contract has increasingly compensated for these deficiencies as more authority has devolved to the Mission and Abt consultants and site managers have gained the Ukrainians’ trust.

The contractor has experienced some difficulties resulting from USAID budgeting and funding cycles, which are congressionally controlled but produce significant delays and uncertainties. In addition, problems surfaced between USAID central contracts and the USAID/Washington COTR.

6. Was the scope of work appropriate?

See above.

7. Will the contractor achieve results?

Yes. See discussion above regarding impact.

8. What are your opinions on cost of operations?

Abt tends to run a high-cost operation. The health officer had to intervene at the beginning to save costs. The lack of a COP during startup increased overall project costs.

9. What were the challenges of implementation?

The planning process was too slow and too extensive. A chronology was described as follows:

Summer 1994	Discovery process
February 1995	Planning process
May 1995	Chief of party Stone comes to Ukraine

Project work will extend for one and one-half years but probably should have been specified for two and one-half years.

The turnover of central ministers of health—five in less than two years—has posed a challenge. (In May 1996, the prime minister was replaced, signaling perhaps more instability in the near future.) The more fundamental challenge in the current context has been the need to build trust among counterparts. Unless the counterpart believes that the technical assistance agent is respectful of past accomplishments and is organized and efficient in pursuing an agenda set by the counterpart, the technical assistance effort will remain ignored.

10. What do you feel were Abt's strengths and weaknesses?

In performing the W/NIS regional aspect of the project, Abt has been able to develop a successful pattern of using short-term consultants who are respected subject matter experts, familiar with the local context, and able to establish trust. The Lviv site manager has been a strong professional. The COP has instituted a good budget process. Abt now has a good work plan for the balance of the project. If the organization accomplishes even two-thirds of its objectives, the Mission should be pleased.

Abt/Kyiv, through its technical consultants, has helped facilitate communications between different levels of government where communications formerly were “top down.” In addition, Abt has recently been successful in identifying and deploying key American technical consultants in health care.

Balancing these strengths has been a weakness in identifying and developing Ukrainian staff to assist in project implementation. Follow-up by the COP with the MOH regarding process actions has been uneven. Abt/Bethesda has not been adequately responsive to the field team's needs despite a strong focus on procedures. *Slowness in responding to staffing needs is the biggest single deficiency.* The program director in Bethesda had too much control in the decision process. Such control should have been delegated to the COP in Kyiv. Abt's overall approach was perceived as technical and research-oriented when the effort called for a more practical, implementation-oriented approach.

Unfortunately, the health officer has had to defend the project to the state coordinator and congressional visitors because of a general perception that Abt has not managed the project

well—despite significant accomplishments and potential for national systemic impact as described elsewhere.

11. Would it have been possible to achieve the goals if USAID had relied more on local groups with limited U.S. oversight presence?

This approach is the preferred model.

12. Is the approach effective to aid and abet health care reform in transition and developing countries?

The “champions” strategy was successful.

For postcommunist transition economies, the concept of modeling specific new administrative and costing techniques at the local level with the support of progressive counterparts, followed by more widespread adoption on a national or regional basis, has worked well to this point.

C. Questions for USAID and Abt Regarding the Next Phase of the Evaluation

- C Who are the local counterparts?
- C What is your best estimate as to how much time is needed in the field and at what sites?
- C Is there a recommended sequence?
- C What are the logistical issues, planes, trains, etc. (we have four weeks to do the fall review)?
- C Are there sites that do not require a visit?

The following is a consolidated recommendation from USAID and Abt regarding the itinerary for the fall visit. The estimated time available for West/NIS is eight working days. The following time allocation is suggested:

Two Days in Kyiv—team orientation, meetings with USAID and Abt

Team splits—one group goes to Lviv, the other to Odessa

Lviv—four days, including a one-day visit to Skole rural rayon

Odessa—three days, then group returns to Kyiv for meetings with MOH

Kyiv—two days for debriefing, missed appointments, and writing

While it is not necessary to visit eastern Ukraine or Moldova, it may be desirable to invite one or two eastern-Ukraine-based project counterparts to Kyiv for meetings. Travel to Lviv and Odessa will be by air.

The USAID Mission did not suggest an optimum time for the next phase. Abt/Kyiv would strongly prefer early October because of known staff travel plans.

See Annex G for lists of counterparts to interview during the second phase.

COP Stone suggested the following as outcomes to be measured:

- C Did aspects of health care reform occur?
- C Did private investment and privatization in the health care sector occur and, if so, to what degree?
- C Were cost savings achieved in the health care sector?
- C Has there been an increase in systemic efficiency?
- C Is there increased local autonomy in health care decision making?

D. Group Dynamics

Within the Abt/Ukraine team, relations appeared to be professionally correct and task-oriented.

Between the USAID Health officer and Abt/Kyiv team, relations appeared to be consistent with professional decorum focused on maintaining project progress. Of late, however, the officer and the team have had little contact.

[THIS PAGE INTENTIONALLY LEFT BLANK]

II. RUSSIA

A. Generic Questions (for both USAID Mission and Abt/Moscow)

1. Was the conceptual framework right (i.e., pick local areas with champions, then pour in technical help)?

Consensus View of the Mission and Abt/Moscow. The original contract called for emphasis on local demonstrations. In practice, however, debates over the correct approach to the conceptual framework consumed a great deal of project time. Abt/Bethesda, in consultation with the USAID COTR Washington, initially envisioned the project as a “national-level approach” in which a national financing system model would be developed by using short-term technical consultants from the United States. Along with the financial system model, the project would develop a legislative and regulatory approach to support the implementation of the financial model. Approximately 70 percent of the project effort would be directed at the national level, with 30 percent of the project work aimed at local-level demonstration sites.

Since the early 1980s, the Soviet health care system had engaged in a limited number of health financing demonstrations, primarily in Siberia. Most of the demonstrations ended in failure because they did not include a health care delivery component necessary to effect the proposed financial approach. The Mission believed that any health care reform effort in Russia had to include health care delivery and financial reforms supported by an information system, with the ultimate goal of improved health care sector performance through better and more cost-effective health care. (Abt/Moscow opined that the consolidated concept proposed by Abt/Bethesda and the Mission failed to include as a goal “the improved health status of the populace.”) Additional goals called for developing new managers who could refine the models based on empirical results and changing political/economic conditions and share with others lessons learned in order to extend project benefits. Thus, Abt/Bethesda viewed the project initially as a “health financing” approach, whereas the Mission viewed it as a “medical delivery system approach.”

Opposition to a “national” approach grew out of the following issues:

- C In 1991, a new national law delegated decision making in the health care system to the oblast (state). In contrast, during most of the contract period, Minister of Health Nechayev’s vision for health care reform called for recentralizing health care decision making; the minister was removed from office six months ago. Even if the minister’s approach had been implemented at the outset of the contract, it would have been difficult to shepherd reforms through national-level ministry personnel, many of whom were members of the former Soviet national health care system. Therefore, it was better to start at the local level and move to the national level.
- C The sheer geographic size of Russia and the differing health needs of its populace meant that a single central approach might not meet the country’s health care reform needs.

Redundant experiments in different health care areas were needed to test the efficacy of an approach before advancing it to the national level.

- C Work at the local level was based on the cooperation of the regional Duma and on the belief that the local officials would be central in effecting permanent changes.
- C The original concept of importing technical assistance from the United States was unpopular with local officials. In an effort to ensure a sustainable result, local leaders requested that local consultants be taught how to perform the work.
- C Many results anticipated from the demonstration work would have been beyond Russia's legal and regulatory framework. Accordingly, revisions to the laws and regulations would be necessary to implement the results. The need for the revisions has been underscored by the rapid changes in Russia that might affect national laws and regulations in the health field.
- C Russia spent only 1.4 percent of its gross domestic product on health, an amount sufficient to cover 8 percent of the costs of the national health care system. Approximately 80 percent of health care budgets are derived from the local level. The remaining contribution comes from the oblast. Therefore, financial reforms coupled with necessary health care delivery changes should be more appropriately directed at the local level.

The demonstration sites were selected after an intensive four-week field investigation conducted by Abt/Mission/Russian counterpart personnel. The Mission believes in retrospect that the correct sites were chosen, although the number of sites was probably too great. The number of sites stretched the logistical ability of Abt to support the effort.

The local health care financing experiments initiated in Siberia in the 1980s had created an environment that was more conducive to experimentation and change than elsewhere. As a result, Siberia was selected for the demonstration.

Challenges to implementing the selected concept included the following:

- C Local and oblast politics;
- C Since the work and the contemplated results were beyond the legal and regulatory environment, local champions had to be "risk takers." In one case, the risk takers were removed from office and accused of misusing the health system money; and
- C The logistical requirements to support the multioffice locations and the multisite demonstration projects were complex. One of the Abt Russian staffs opined that it would have been better from "results and logistical" points of view to select a few communities

and then operate demonstration sites in all of the institutions within the selected communities.

Differences between USAID/Moscow and USAID/Washington culminated in the decision to transfer control of the project to a contracting officer's technical representative (COTR) in Moscow and to replace the Abt country director in Russia. Despite the improvements brought about by these changes, the following weaknesses persisted:

- C When the large CIS contract with Abt was split into three parts, no mechanism was put into place for "cross-fertilization" between the field personnel and Russian counterparts of the three contractual areas; and
- C No comparative data set was developed to allow comparison of the costs of health care reform in the CIS. The "task order" system developed by Abt would have easily supported this idea.

One worry of the Russian counterparts is that the "follow-on" project may be premature (see Section 5 below). The experiments need more time to work and to generate results before information dissemination can begin. Some of the projects have been underway for only a short period. The concept of rapid dissemination may be counterproductive.

A side benefit of that concept was that the project would be able to leverage its effort with the participation of other donor programs such as the World Bank efforts in Kaluga and Tver.

**2. Did they hit the right targets in terms of institution building (hospitals, polyclinics, insurance)?
What were the main targets?**

Consensus View of the Mission and Abt/Moscow. The Mission and Abt/Moscow agreed that the regional/local approach was the proper one and that the geographically concentrated approach was also correct. Nonetheless, the Mission viewed the overall approach as a rejection of the intensive demonstration site concept initially proposed by Abt. Abt/Moscow and the Russian government counterparts saw the "intensive demonstration site" concept on a slightly larger geographic basis. All agreed that effecting permanent, sustainable health reform was contingent on a reform of the health care delivery and health financing systems as supported by the development of an information system. The Russian government counterparts concurred. The Russian/American teams deployed at the local sites were considered "a plus."

The Moscow COTR argued that the one area insufficiently developed was "cost effectiveness." The COTR questioned whether the implementation of demonstration sites in six oblasts was too ambitious. In addition, Abt/Moscow identified some unnecessary redundancy in sites for risk management. It strained the logistical ability of the contractor to support the project and stretched the available money too thin. Abt/Moscow also opined that

the large grant portfolio required additional resources not contemplated in the original contract.

The Abt Russian staff offered that a great deal of work already had been accomplished by local officials through the experimentation process initiated in the 1980s. Thus, the project provided a good balance between the work previously performed and currently underway and the project work. Abt noted concern among the Russian health officials that the demonstrations were conducted in facilities providing ongoing health care to the populace. The prospect of an integrated delivery system caused fear among the institutional officials that the accompanying “risk taking” inherent in such an integrated system would adversely affect funding sources and jeopardize an institution’s ability to perform its required work. The grants and the technical work provided by the project team reduced fears and increased the willingness of officials to participate in the project.

3. Were the project’s processes effective in achieving the goals within the conceptual framework (grants, training, information dissemination, finance and administration, regional programs)?

See Annex O.

Consensus view of the Mission and Abt/Moscow

- C Is the in-place cost-accounting system effective? **Yes**
- C Is it permitting you to identify cost and task sufficiently? **Yes**
- C What is the price tag for the specific reforms we are trying to promote (i.e., moving care from hospital to clinics)? **The TO system allows most costs to be discretely identified. Certain general costs would need to be spread to the various TOs for each year.**
- C Did the cost-accounting system facilitate communications when objectives or budgets changed? **Yes**
- C Did small grant programs support the idea of health reform? **Yes**

The task order system was created with difficulty. The Moscow COTR feels that, as constructed, it is effective in managing the project. The health officer does not necessarily recommend the system for other possible health care reform projects.

Processes/projects that are working well include the following:

- C financial modeling (seven models developed);
- C actuarial insurance modeling (beneficiary system);
- C restructuring care from a hospital to a polyclinic, with incentives for physicians;
- C leadership development;
- C quality improvement;
- C management information system development in electronic medical records and moving programming from DOS to Windows environment; and
- C technical training (actuarial, financial, MIS, physician, administrative) (2,100 physicians trained, study tours to other countries completed, publications developed and some distributed).

4. Considering that reform comes in incremental advances, will the project get results?

Do the projects show promise?

What reforms do you believe have been most effective?

USAID. The project will achieve results. Many Russian counterparts are being invited to present lessons learned to other oblasts. The quality indicators, financial projects, and electronic library are examples of the building blocks that can be used as tools for reform.

The dissemination of information through a CD-ROM offers promise. It contains 10,000 pages from 300 selected articles on system improvement and other topics. The articles have been translated into Russian. The CD-ROM includes a search engine that looks up functions by key words, phrases, article title, and author. (Note: Abt demonstrated this system for the advance team.)

There are 38 small grant projects underway; many offer promise (see Annex P).

Abt. Abt agreed with the above and added the following:

- C The medical system needs to be modernized in many ways. The translation and dissemination of Western evidence-based scientific medical journals and books will allow the medical community to develop more fully. Russia has not yet achieved international standards of medical knowledge, but it is a position that could allow it to “leap frog” from many outdated practices still in use (e.g., 30-day hospitalization for ulcer pain with daily endoscopy and laser treatments) to current medical practices. There are 650,000 physicians in Russia, but the largest circulation of any medical journal is

15,000. Low-cost dissemination of information through CD-ROM or the World Wide Web could allow physicians to improve their practices. In addition, the medical curriculum needs modernization and should enter into a partnership with the American medical establishment. (See Annex M for two specific examples of the models developed through the project.)

- C The development of extragovernmental associations is needed to enhance medical professionals' standing and allow development of professional standards for credentials.
- C The reforms instituted at the regional level may, in some cases, translate into national policy. It was noted, however, that the current extent of decentralization may have swung the pendulum too far from the minimum centralized regulatory and standards authority required for wide distribution of models across the system. Fundamental rules, regulations, and statutes are needed to create national standards and to promote certain efficiencies and protections. (For example, informed consent for surgeries is not required and usually not considered.)
- C Russia has promulgated medical economic standards for diagnostic categories to guide clinical practice. The standards are enforced by payment penalties. If they are not met, an institution can be paid less for care that may not be indicated but that is required under the standard. The standards are general and do not allow for the typical variation that occurs with many patients. In several cases, the standards call for overuse of resources.

5. Cross-Cutting Issues

Dissemination of ZdravReform products. Abt COP Rice noted that dissemination is “the Achilles heel” of the project. USAID/Moscow is concerned that budgetary constraints affecting the Russia component may preclude the preparation and optimal distribution of CD-ROMs containing translations of literature on health care system management. With only a small amount of money involved, it would be unfortunate if internal budget issues prevented distribution of 2,000 copies of the CD-ROM, which, according to USAID and Abt/Moscow, is the required minimum distribution.

The advance team was advised that AID/Washington is considering the idea of translating a set of lessons learned about the ZdravReform project from the three regions and incorporating them into a CD-ROM. The coordinated distribution of the various CD-ROMs and possible combination into a single disk should be considered.

New Grant Project. USAID is in the process of awarding a \$2.5 million grant for health care sector reform. The grant will have a significant role in the future dissemination of

ZdravReform products. The RFA for the grant described the following three activity categories:

- C Legal and regulatory
- C Investment advice
- C Dissemination

Depending on the proposal selected for funding, several current USAID and Abt/Russia staff could participate in the implementation of the grant. Individuals would include Susan Cheney, Stanley Tillinghast, Kevin Woodard, and Igor Sheiman.

Coordination. USAID did not inform Abt of possible synergy of activities and work with counterparts arising from other USAID-funded projects. In some cases, two contractors were working with the same local counterpart.

B. Questions for USAID/Moscow

1. How is the Mission organized?

The ZdravReform project is managed by USPSC Senior Health Advisor Susan Cheney (EDD July 1, 1996). Her replacement, also to be a USPSC, is currently being recruited. The senior health adviser reports to Terrence Tiffany, Director of the Office of Environment and Health and the COTR for the project, and is assisted by a local hire physician (Tamara Siribiladze).

2. What are their strategic objectives?

The pertinent strategic objective is “Improved Effectiveness of Social Benefits and Services.” Project contributions to impact indicators are being tracked by Abt and, per Abt, will be met or exceeded (see Annex L).

3. What and why course corrections?

The Russia component of the ZdravReform project underwent a major course correction, embodied in Modification No. 6 (mod six) to Abt’s contract with USAID. Negotiations on the modification began in December 1994. The modification was finally signed in July 1995 but was retroactive to February 1995 to validate mutually agreed actions taken before the signing.

In sum, mod six transferred COTR authority to USAID/Moscow (Tiffany) and technical direction for the Russia component from Abt/Bethesda to the field project director (Rice). Mod six also recognized that the Russia component would focus on service delivery and not

only or mainly on financial management issues. The implementation approach of the Russia component also called for using a much larger proportion of Russians as technical advisers and implementors than was envisaged under the original contract. The grants program was expanded. Kaluga and Tver oblasts were added after the modification of the contract, with the objective of providing technical assistance to support a seven-year World Bank loan program aimed at overhauling the entire health care delivery system in these oblasts.

Mod six was required to resolve a number of issues that had arisen since Abt was awarded the contract in December 1993. The fundamental issue was how to deal with the rapidly evolving situation in Russia where substantial and effective devolution of powers to the regional (oblast) and district (rayon) level had occurred. The earlier concept of focusing technical assistance at the national level was no longer practical. Further, the project's primary implementation challenge proved to be the need to hire and manage a large group (about 90) of Russian technical specialists and to manage the small grants program (38 grants have been awarded).

Defining the scope of work and gaining consensus on it through the country action plan was clearly not effective.

Staff described the following chronology covering approximately the first two years of the project:

Mid-1993—USAID issued a broad RFP not typical of the standard contracting process. USAID/Washington “took over” the review and award process. Per USAID/Moscow, the Abt bid was described as a financing-type project.

December 1993—Abt was awarded the contract. USAID/Washington was the COTR for the contract.

June 1994—A team of USAID and Abt staff went to the field to perform a detailed technical and programming assessment.

July 1994—USAID submitted a draft country work plan that did not adequately reflect the June 1994 technical assessment. Abt/Bethesda was unwilling to modify its approach. Leadership issues with COP and Abt corporate were noted. USAID/Moscow felt it needed more control to direct the course of the country work plan, which was neither comprehensive nor directed at the areas identified in the June 1994 plan.

December 1994—The national-level interface was removed as an Abt responsibility.

February 1995—Mod 6 becomes applicable and assigns COTR responsibility to Moscow. The funding available for the Russia program is reduced from \$26,000,000 to \$19,302,019. A new COP was hired (Jim Rice). USAID was involved in the interview process. Rice's appointment was a turning point in the project.

February 1995 to the present—The project has developed satisfactorily. The resident team has done “a phenomenal job.” USAID/Moscow has had voucher approval for about seven months, allowing greater control of expenditures and sharper focus on the part of Abt.

July 1995—The country work plan is approved.

Key observations concerning the second phase of the project follow:

The task order system has been an effective way to manage the Abt contract’s progress and costs.

The selection of personnel has remained a concern. The checking of references and overall evaluation of the capabilities of many candidates has not been adequate. The initial review team did not include enough medical professionals, which created a narrower point of view on project scope.

The support from the Abt home office seems excessive (\$750,000), and deliverables from that office are not visible to Moscow in many ways. Communication between USAID/Moscow and Abt/Bethesda over the past year has been limited.

The grants process has been effective; however, it will be difficult to evaluate the grants because many do not conclude until November 1996, by which time Abt will have been released. The grants’ actual impact will not be known until well beyond project conclusion.

The process of orienting U.S. technical experts required adjustments. This situation became less of a problem as Abt settled on a resident U.S. team that could brief experts on the system before their arrival in the field, thus avoiding frustration and miscommunication between Russians and first-time U.S. technical advisers.

The procurement of computers has been especially problematic. A detailed list of equipment and software was submitted in October 1994 to Abt/Bethesda for approximately \$600,000. USAID did not receive the request until June 1995; and the equipment did not arrive until May 1996. A series of communication and technical issues impeded the fulfillment of the order. (It should be noted that the technical specifications required by USAID greatly reduced the number of options available to the contractor. When finally shipped, the PCs contained 486 processors rather than the Pentium types that are now the industry standard.)

The budget and voucher process is complicated and has resulted in many revisions. Issues include home office billing and the number of revisions to authorized budgeted amounts.

The delays in approval of the country work plan and delivery of the computers has deferred several projects and processes.

4. What issues do you have?

The senior health adviser has been continually required to defend health care reform as an appropriate area of involvement for U.S. assistance to Russia vis à vis congressional staffers and the State Department coordinator. Briefing materials have been developed by USAID/Moscow to elucidate the linkage between health care reform and systemic change.

Abt's performance under the contract has been a fundamental issue during the entire period of performance. Abt's performance was a principal factor in USAID/Moscow's decision not to exercise the optional two-year extension of the Russia component and to address health care sector reform issues in Russia through alternative mechanisms.

The contractor has performed particularly poorly in the area of personnel recruitment and procurement. The Abt/Bethesda program director (Pielemeier) has resisted making changes in the contract and failed to recognize fully differences between managing technical assistance in Russia and the typical LDC situation. The first Abt country director (Koprowski) was unable to perform his role as chief of party and was released after a few months. Abt could have possibly prevented Koprowski's departure by checking his references, which it allegedly failed to do.

5. Was the contract well designed?

For reasons based on the uniqueness of the situation in the former Soviet Union, the contract was broad and required adjustment. In accordance with USAID's initial understanding of the situation, the contract was structured to deal with health care finance; in fact, the situation required the technical assistance effort to address service delivery.

6. Was the scope of work appropriate?

See above. The original scope of work was modified to take into account the need to provide technical assistance through Russian-American professional collaboration, thereby reducing the required number of short-term expatriate consultants. In addition, the "national level" technical assistance function was taken away from Abt by USAID.

The previous USAID senior health adviser (LeSar) selected four contiguous oblasts in western Siberia as the prime project sites on the theory that geographic concentration would offer logistical advantages while responding to an early process of reform, particularly in Kemerovo oblast. The distances in Siberia have proved so great, however, that the project team has found few benefits from this arrangement and now believes that it should have selected a single oblast in each of Russia's main population areas (i.e., central, south, Siberia, Far East).

7. Will the contractor achieve results?

Led by Jim Rice, the local contract team has worked collaboratively with USAID/Moscow and has achieved significant progress in a short time, reflecting skillful use of Russian professional leadership and technical competencies. The technical assistance effort can be best characterized as “seed planting” with an immediate response from Russian counterparts who are eager for new tools and prepared to innovate. Thousands of pages of professional literature have been translated; over 2,000 Russians have been trained in country and in carefully selected study tours in the United States and United Kingdom; 38 small grants have begun testing a wide variety of new approaches to service delivery, quality assurance, financial management, and payment plans. Many activities show great promise. Kaluga oblast will likely enter a sustained process of reform with World Bank assistance based on models developed by the ZdravReform project.

Unfortunately, the project will not be wrapped up as neatly as had been hoped. The grants are not due to be completed until the end of 1996, with some results not suited to measurement for some time thereafter.

The follow-on grant project, which is currently being awarded, will help ensure continuity and dissemination of key ZdravReform products.

8. What are your opinions on cost of operations?

The primary concern has been reconciliation of the level of effort approved in the task orders with the vouchers submitted by Abt. Abt has tended to embed in task order budgets unneeded services and trips by Bethesda-based staff. The USAID senior health adviser had to “scrub” budgets in a time-consuming and frustrating process. Abt’s costs could have been lower. Abt/Moscow staff are imbued with a sense of fiscal responsibility; all evidence concern for cost management to ensure achievement of the highest “return on investment.”

9. What are the challenges of implementation?

The sociopolitical environment that greeted the project managers was unique and highly complicated. Devolution of power to regional and district levels had made the federal health ministry less relevant and provided flexibility for experimentation. Yet some kind of central approval will remain important to the spread and acceptance of the reform practices that might be tested and validated by the project. Minister of Health Nechayev was an old-guard communist who publicly alleged that foreign technical assistance staff were intelligence agents. Nechayev was finally fired in disgrace after the doctors’ association unmasked his lies on television. But Nechayev’s successor has not been much of an improvement.

By law, health management organizations may not be formed; yet, the situation calls out for new payment systems.

Predictably, logistics and communications were difficult. Waivers were needed to hire Russian staff.

The project, along with other USAID programs in Russia, has operated without the benefit of a bilateral agreement with the government of Russia concerning U.S. assistance.

10. What do you feel were Abt’s strengths and weaknesses?

Even though the quality of Abt’s work elsewhere (including the Russian officers’ housing project) has earned recognition, Abt’s management of ZdravReform was characterized by resistance to USAID guidance, particularly in the case of shifting the project from a narrow focus on health financing to service delivery.

Despite a “fantastic, once-in-a-century” opportunity for significant health care reform in a major country, USAID and Abt could not seem to pull together until the arrival of Jim Rice; even after his arrival, relations with Abt/Bethesda have remained strained.

Even though he was not the responsible contracting officer for the contract, the Moscow-based contracting officer (Yeandel) has had to spend an inordinate amount of time with Abt staff on computer procurement and other issues. Abt/Bethesda staff seemed unable or unwilling to recognize the need to assist in procurement, and it was alleged that they were disingenuous in dealing with local staff whose contracts were terminating as a result of USAID funding cutbacks.

11. Would it have been possible to achieve the goals if USAID had made greater use of local groups, with a small American oversight presence?

The project evolved toward such a model.

12. Could we have done it better? If yes, how?

A greater effort at dialogue and communication with Abt/Bethesda and the original USAID/Washington COTR (MacDonald) might have helped resolve some issues.

13. Is the approach effective in aiding and abetting health care reform in transition and developing countries?

In Russia, local autonomy had been granted and health care administrators were prepared to experiment. The issue was how best to prepare and communicate materials and models to facilitate experimentation. The project has generated a large number of models for study and replication that will have wide applicability.

C. Questions for USAID and Abt Regarding the Next Phase of Evaluation

- C Who are the local counterparts?
- C What is your best estimate of how much time is needed in the field and at what sites?
- C Is there a recommended sequence?
- C What are the logistical issues at present: planes, trains, etc. (we have four weeks to do the fall review)?
- C Are there sites that do not need a visit?

USAID. The evaluation should be expressly designated as an evaluation of Abt's performance. The starting point is to recognize that successes in Russia occurred in spite of, not because of, Abt/Bethesda; it is important that Abt not take credit in a general sense for the overall success of the program in Russia, which was due to USAID/Moscow's vision, guidance, and subsequent effective collaboration with the local Abt team following Jim Rice's arrival as COP.

The second-phase evaluators should speak with Barbara Brocker, the contracting officer, or with the contract project specialist, Casey Finnerty, at (703) 875-1664.

Timing of second phase—The later the better; September is not acceptable for two reasons:

- C Abt will be closing its Moscow office at the end of September and will be preparing a number of final reports; USAID will be closing out the fiscal year.
- C The grant projects will be closer to completion and hence more evaluable.

Overall, the evaluation in Russia will require about ten working days, allocated as follows:

Western Siberia—four days, meeting with oblast counterparts and some grant holders
Kaluga/Tula—one day
Tver—one day
St. Petersburg—optional
Moscow—two days

Abt. Abt also suggests ten working days for a long-term visit or one week for a “compressed” visit should that become necessary. (Abt will supply the itinerary for the short visit.)

Western Siberia—five days

Sequencing: Fly to Kemerovo from Moscow (one day in Kemerovo)
Drive to Tomsk (one day in Tomsk)
Drive to Novosibirsk (half day in Novosibirsk)
Drive to Barnaul (half day in Barnaul)
Fly to Moscow from Barnaul

Kaluga/Tula—one day trip from Moscow

Tver—one day trip from Moscow

Moscow—two to three days; topics for Moscow:

- C Federal funds (recent Yeltsin decree may result in changes to how insurance funds are made available to the regions)
- C Ministry of Health (review how lessons learned can be translated into national policy)
- C Management training

The Abt office space in Moscow will be available until the end of December. The departure schedule for Abt local staff is as follows:

Rice	June 2
Sheiman and Makarova	End of September
Woodard	End of July
Tillinghast	Mid-September
Langenbrenner	End of July (acting COP upon Rice's departure)
Poer	Mid-August (depends on R&R schedule)
Solovieva	End of November

Key Abt local staff for second phase of evaluation are Sheiman, Makarova, and Solovieva. Julia Solovieva is a grants administrator. Igor Sheiman is a health economist who knows all the counterparts; Tanya Makarova is his assistant. It may be possible to hire Igor and Tanya on a local hire basis, though they may be working elsewhere in October. Suggested interviewees are provided in Annex N.

D. Group Dynamics

Within the Abt/Russia team, deep professional and personal respect for COP Rice is evident. Relations appeared to be professionally and personally cordial, with a strongly shared sense of values and priorities.

Between USAID/Moscow and Abt/Russia team, close professional collaboration, friendship, and respect are evident.